SEVENTH ANNUAL REPORT ON MEDICARE COVERING FISCAL YEAR 1973

COMMUNICATION

FROM

SECRETARY OF HEALTH, EDUCATION, AND WELFARE

THE SEVENTH ANNUAL REPORT ON MEDICARE, COVERING FISCAL YEAR 1973, PURSUANT TO SECTION 1875(b) OF THE SOCIAL SECURITY ACT, AS AMENDED [42 USC 1395(b)]

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LETTER OF TRANSMITTAL

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

JAN 14 1975

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

Dear Mr. Speaker:

Transmitted herewith is the Seventh Annual Report on Medicare, covering the program's operation during fiscal year 1973. As you know, this report is required by Section 1875(b) of the Social Security Act, as amended.

As you will note from the content of this report, the major activities of the Medicare program in its seventh year of operation were directed to the implementation of the broad scope of legislation embodied in the Social Security Amendments of 1972. This activity will continue to dominate the administration of Medicare throughout the current year and for some time to come.

Sincerely,

Caspar W. Weinberger
Secretary

Enclosure

REPORT ON MEDICARE

FROM

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

The Seventh Annual Report on the Operation of the Medicare Program, Pursuant to Section 1875(b) of the Social Security Act

July 1, 1972 to June 30, 1973

FOREWORD

The year covered by this Seventh Annual Report (July 1, 1972-June 30, 1973) saw the most profound changes in Medicare that have occurred since the passage of the original legislation in 1965. After nearly three years of Congressional deliberation, the Social Security Amendments of 1972 were enacted in October of that year. The Medicare provisions of that legislation extended over a wide range of program dimensions.

Two highly significant extensions of coverage were authorized by the new legislation--the coverage of individuals under age 65 who had been entitled to social security disability benefits for 24 months or more and the coverage of individuals suffering from severe chronic renal disease, regardless of their social security disability status or their age, if they require regular dialysis treatment or kidney transplantation. The extension of coverage to disability beneficiaries was accommodated within the existing administrative and procedural framework of the Medicare program and the primary impact of this new coverage will lie in the increased costs and the increased bill processing resulting from the expected higher use of medical services by this group as compared to the elderly. On the other hand, the extension of coverage to individuals with chronic renal disease involves extensive administrative and procedural changes in both claims processing and reimbursement and will require the development of review boards to screen the appropriateness of care patterns as well as minimal utilization rates for facility participation. The decisions of the Federal Government in this area are likely to have a considerable influence on the entire delivery system for furnishing renal disease treatment services. There were two lesser extensions of coverage resulting from the new legislation--coverage of chiropractic services on a limited basis and coverage of independently practicing physical therapists on a limited reimbursement basis. The special problems associated with these two extensions of coverage lie in establishing criteria for assuring professional qualifications and, in the case of chiropractic, sharply defining the limited therapeutic services to which coverage was extended.

Important long-range program effects may be expected from the various provisions which address themselves to cost containment and the expanded authority assigned to the Department to support economical alternatives to existing delivery mechanisms wherever such alternatives are consistent with prevailing quality care standards within the professional community. Among the more important of these provisions are: the establishment of Professional Standards Review Organizations (PSROs), physician-directed review mechanisms to monitor the utilization and the professional quality of services provided to Medicare and Medicaid beneficiaries; the creation of a Health Maintenance Organization (HMO) option to adapt Medicare reimbursement so that it will be more supportive of this alternative delivery mechanism; the increase in authority for the Secretary to engage

in broad experimental activity both in reimbursement methods and in coverage alternatives under the various health programs of the Department; and a number of other provisions which will support program initiatives toward more economically efficient delivery of services by participating health care facilities.

A number of changes in the new legislation address themselves to the correction of certain program features which had produced inequities for various groups affected by the program. One of the major problems, for example, in any insurance program which determines coverage after the receipt of services, is that there is a potential hardship to the beneficiary when the services are determined not to be covered. Most beneficiaries are not able to make valid judgments about the medical necessity of the services being furnished. As a result, particularly in the area of skilled nursing facility care, periods of stay not covered by the limited Medicare provisions for such care were sometimes denied retroactively and beneficiaries often found themselves liable for unanticipated payments from their own funds. The 1972 amendments introduced two special features which should have the effect of reducing to a considerable degree the frequency of retroactive liability. The first provision allows the program to waive beneficiary liability where the patient receives institutional or other services which are determined either to be medically unnecessary or to constitute custodial care, if such services were accepted in good faith and the patient could not be expected to have known that they were either unnecessary or noncovered. The second provision provides for advance approval of initial periods of stay in a skilled nursing facility or an initial series of home health visits so that during the guarantee period, definitive determinations can be made in respect to the continued coverage of such services. In this way, the beneficiary does not run the risk of liability for services received during that period even though, after presentation of evidence the services were found not to meet Medicare coverage requirements.

During fiscal year 1973, Medicare was intensely involved in developing implementing policies and procedures and in preparing necessary regulations to reflect this large body of statutory change. A substantial part of this Seventh Annual Report describes this activity. During the course of this fiscal year a number of ongoing program activities also resulted in improvements in over-all Medicare administration and claims processing performance. These actions are described in detail in the following pages, but particular emphasis should be given to the steps taken to improve the State agency inspection process, particularly in the area of fire safety enforcement; to the increased control of intermediary and carrier expenditures brought about by the renegotiation of contracts; to the recovery of unwarranted benefit disbursements through civil fraud prosecution under the False Claims Act; and to the achievement of more effective decentralization of program activities to regional offices.

As Medicare entered its eighth year, it faced new challenges and new mandates, both from the public and from the Congress--but it had also been given significant new authority so that, in continuing cooperation with the health community, a greater potential than ever before existed to more fully realize the essential purposes of Medicare.

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PART I - THE MEDICARE CLAIMS PROCESS

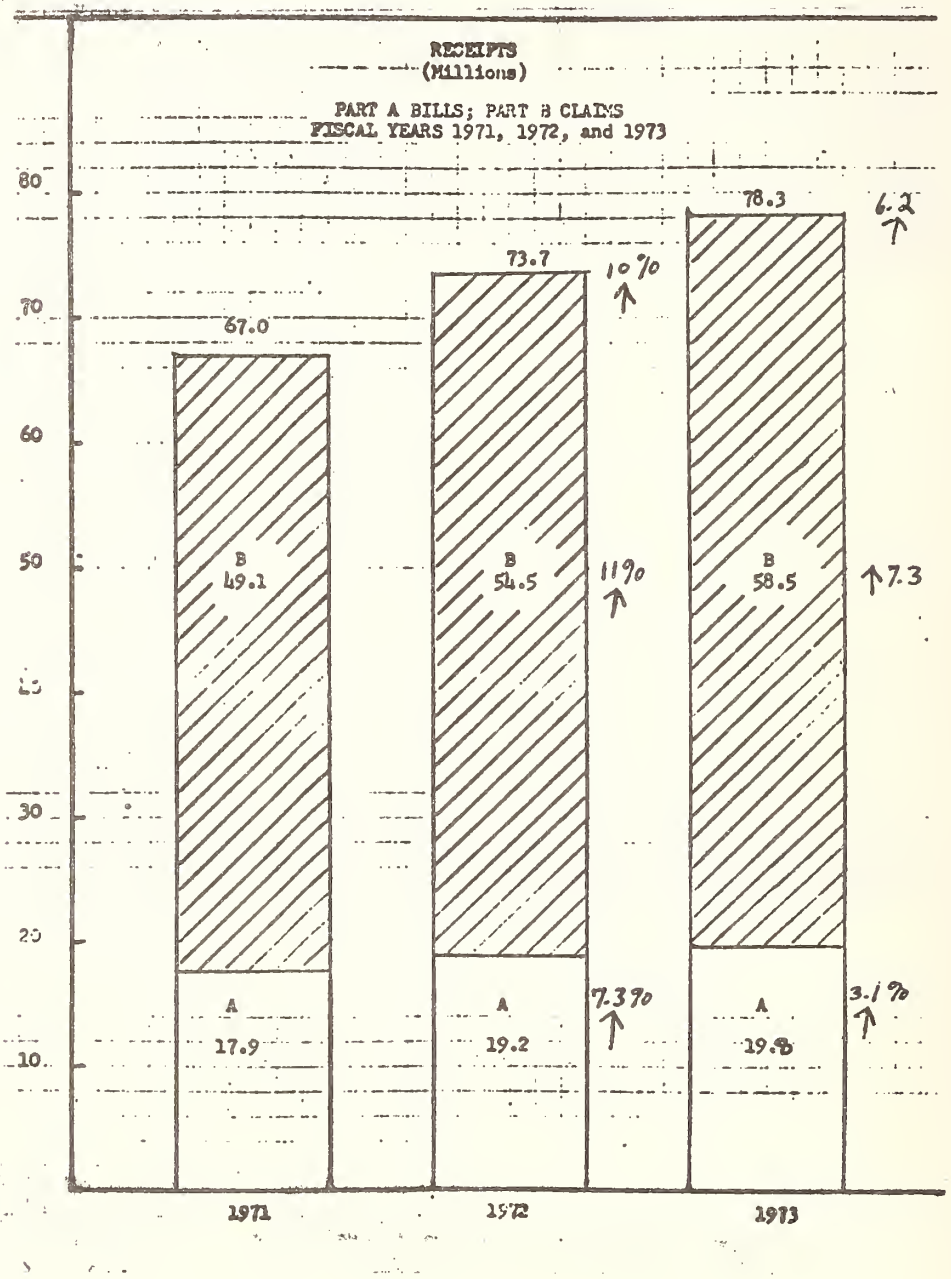
Medicare claims processing and bill payment is essentially performed by intermediaries (hospital insurance) and carriers (medical insurance). 1/ Intermediaries and carriers are commercial insurance companies and Blue Cross-Blue Shield plans whose participation in administration of the program was stipulated by the original Medicare legislation. Intermediaries processed almost 20 million hospital and other Part A bills during FY 1973, and carriers processed over 58 million claims for physicians' and other medical services.

The various workload and financial reports which intermediaries and carriers are required to submit for a reporting period permit the evaluation of their operations and the costs of those operations. Thus, Medicare is able to monitor not only the quantity of work being done but also the quality of performance against specific criteria; e.g., timeliness, accuracy, economic efficiency, etc. The monitoring system provides pertinent data for each intermediary and carrier and permits the computation of national averages for broad comparison purposes. When significant disparities between individual performance and national averages are identified, necessary corrective action is undertaken.

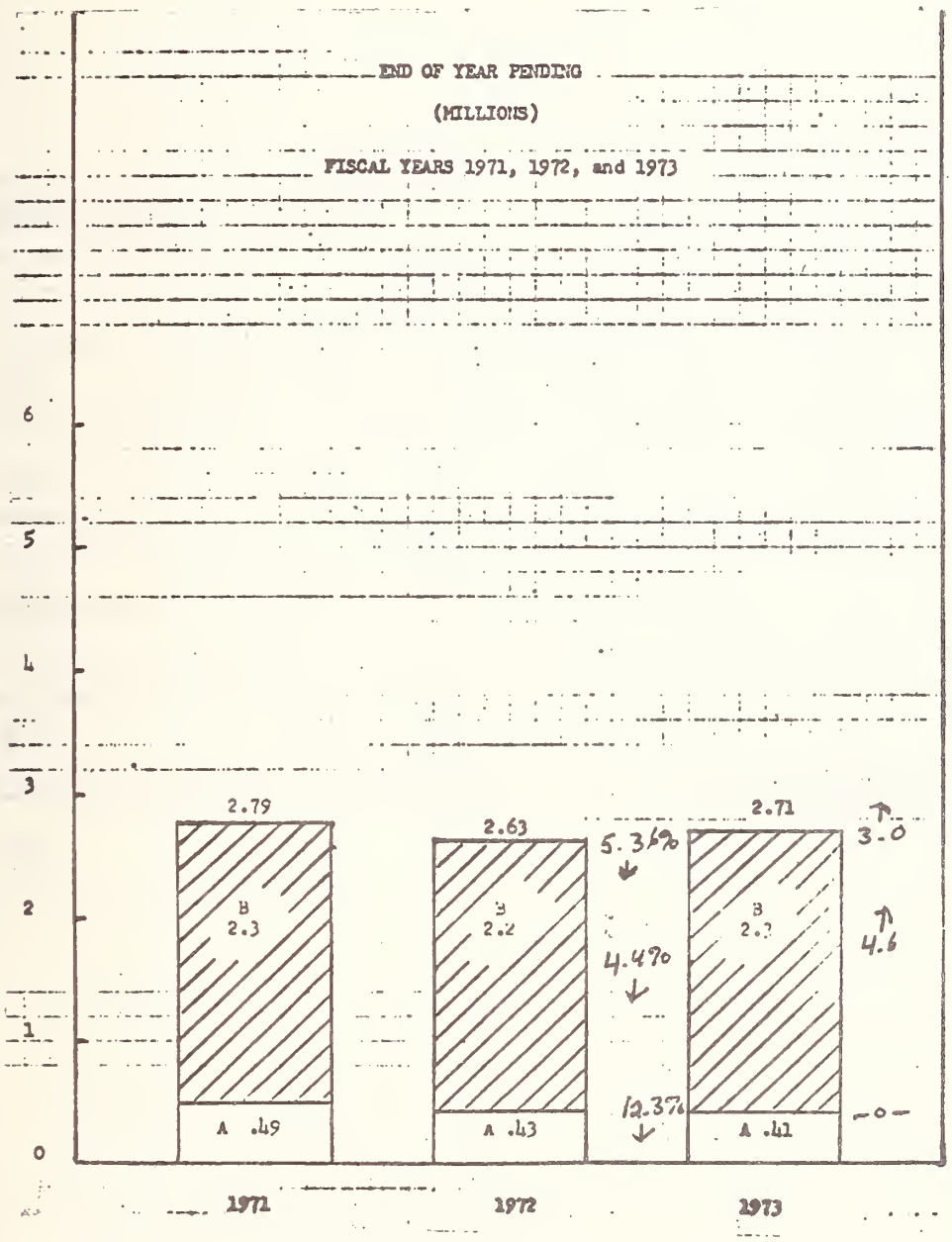
1/ A complete listing of intermediaries and carriers for the Medicare program is in Appendix D, Exhibit 2.

Claims Workloads and Processing Time

While the absolute number of claims increased during FY 1973, the rate of increase of both Part A and Part B claims received was lower than in previous years. Part A bills were up 3.1 percent to 19.8 million and Part B claims were up 7.3 percent to 58.5 million.



The end-of-year pendings showed only a 3 percent increase, from 2.63 million to 2.71 million. This compares favorably with the 6.2 percent increase in total claims received.



Mean processing time for Part A intermediaries was significantly lower in the first two quarters of FY 1973. The yearly average for percentage of bills pending over 30 days is slightly higher than in FY 1973. This is mainly due to the impact of recent instructions which require stricter controls on incoming bills until they are paid or denied.

PART A

	Contractor Processing Time (Mean Days)		Percentage of Bills Pending Over 30 Days	
Quarter	1972	1973	1972	1973
1	11.4	9.5	15.9	17.3
2	12.7	10.3	17.4	16.9
3	12.1	9.9	16.0	15.9
4	10.3	9.8	15.8	17.9
Yearly Average	11.6	9.9	16.3	17.0

Average processing time for Part B bills continued to decrease. It is expected that further utilization of automated systems in Part B claims processing by carriers will continue this favorable trend.

PART B

	Contractor Processing Time (Days)		Percentage of Claims Pending Over 30 Days	
Quarter	1972	1973	1972	1973
1	21.9	18.9	23.4	17.5
2	19.4	19.3	18.1	15.9
3	22.4	21.4	20.2	23.3
4	19.8	19.4	17.4	20.0
Yearly Average	20.9	19.8	19.8	19.1

Annual Contractor Evaluation Reports (ACER)

During 1973, the first of a series of what are to be annual summaries of ongoing evaluations of each Medicare contractor was prepared covering calendar year 1972. The ACER represents our formal evaluation of each respective contractor's performance. The ACER appraises all major facets of each contractor's Medicare operations for the past year, and reflects the continuing assessment of contractor performance. In formulating the ACER concept, the Bureau of Health Insurance (BHI)1/ brought about an almost total transition from centralized to regionalized responsibility for the evaluation of ongoing contractor performance. This, coupled with the further delegation of authority to the regions during the year, has allowed BHI to achieve a truly decentralized system of program administration while at the same time effectively satisfying the various "Freedom of Information" provisions.

Contractor Evaluation and Performance Standards

During the last two years a series of meetings and workshops have been held with carrier representatives to develop revisions to carrier evaluation programs. The major areas to be evaluated are cost of contractor performance, timeliness of claims processing, and quality of claims processed.

As a result of these meetings a Quality Assurance Program was developed and is being implemented. The new system's performance data will be provided by carrier-performed quality reviews (audits) of a scientifically selected sample of claims. These quality reviews will provide the carrier with accurate and timely performance data covering the number of clerical processing errors associated with its adjudicated claims and the claims allowance errors (i.e., underallowances and overallowances) caused by these clerical errors. BHI will conduct subsample reviews of the carrier-reviewed claims to assure a uniformly high degree of accuracy in the review process.

In the area of timeliness, we have developed a more comprehensive breakdown of processed and pending claims which will permit a more accurate and equitable evaluation of this aspect of carrier performance. With respect to cost effectiveness, various factors beyond the contractor's control are being taken into account so that a more meaningful evaluation can be performed.

Revision of Intermediary/Carrier Agreements with the Secretary

In July 1973, SSA completed the renegotiation of the most substantial and significant revisions in the prime agreements since the inception of the Medicare program. Major features of the revised agreements are provisions relating to the budgeting and control of administrative costs, which includes authority for the Secretary to order abatement of certain activities if the required contractor explanation of variances from

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1/ See Appendix D for a description of the administrative structure of the Medicare program.

budgeted funds is unsatisfactory and a satisfactory corrective plan cannot be agreed upon. The revised agreements also contain more specific guidelines with respect to the subcontracting of services and activities on a competitive basis with special requirements for notice and prior approval where major changes in automated data processing activities are contemplated. The agreements now provide for prior approval and cost analysis where adequate competition does not exist, including a certification of accuracy which could result in later adjustments if the analyses are defective. The revised agreements clarify and make more specific the Secretary's authority to have access to and use of information and data generated by Medicare contractors. For the first time, the agreements give the Secretary authority to modify the agreements, as necessary, to accommodate the requirements of P.L. 92-603 or any future Medicare legislation.

Delegations of Authority to Health Insurance Regional Representatives

As part of the effort to decentralize more Medicare operations, significant authority was delegated to BHI regional representatives in 1972 and 1973 for monitoring intermediary/carrier performance. Those delegations include, for the first time, authority to negotiate, approve, or disapprove budgets and final closing agreements for single-State intermediaries and carriers, including all Blue Cross Plans. In addition, regional offices may negotiate and approve or disapprove budgets and final closing agreements for multi-State carriers and intermediaries, under the condition that approvals must be reviewed and concurred in by the central office.

Monitoring Provider Cost Report Processing

An automated system has been developed to furnish more complete and timely data on the progress of intermediaries in obtaining provider cost reports and processing them to final settlement. The system places emphasis on each stage in the processing cycle and focuses efforts on the movement of cost reports through each processing step. The system contains a mechanism for workflow control, audit cost control, and cost effectiveness analysis, and it is expected to provide both intermediaries and the Government with financial and statistical data for more effective management of the entire audit process. It should also provide more effective monitoring of contractor audit subcontracting activities and expenditures and should enable us to evaluate and compare intermediary performance in carrying out audit responsibilities.

Reduction of Medicare Bank Balances

During FY 1973, Medicare carriers and intermediaries were continuously urged to minimize bank balances which they maintain in special bank accounts established to cover checks issued for reimbursement under hospital and supplementary medical insurance. As of the end of June 1973, those balances had been reduced to $81.5 million, which was $34.5 million

less than the $116 million outstanding as of December 31, 1972. As a result of the methods being used to control the bank float, the Hospital Insurance and Supplementary Medical Insurance Trust Funds are now realizing estimated savings of approximately $1.1 million per year. Further savings are anticipated as Medicare further refines its banking techniques.

Banking Medicare Funds in Minority Banks

The President's Executive Order No. 11458, issued in 1969, encouraged all Federal agencies to deposit funds in minority-owned banks. Presently, through SSA and Treasury Department efforts, contractors have signed bank agreements with 14 minority banking institutions with an average daily bank balance of approximately $6 million. The decrease in the average balance from the previous report is attributed to the implementation of the delay of drawdown technique by the various Medicare contractors. As described in the preceding section, this method is being applied nationally to all banks receiving deposits of Federal funds from the Medicare program in order to minimize the loss of interest to the Trust Funds.

SSA is making every effort to encourage contractors to open accounts with minority banks and expect additional bank agreements to be signed in the future.

SYSTEMS AND PROCEDURAL IMPROVEMENTS

Part A Model Systems

The Bureau authorized the Blue Cross Association (BCA) to develop a standardized claims processing system. This system which consists of computer programs, systems and program documentation, and operational instructions was implemented at six additional Blue Cross Plans during FY 1973, bringing the total number of users to fourteen. It is expected that the system will be implemented at several additional locations during FY 1974. Concurrently, BCA is evaluating the functional requirements that most economically can be performed by the computer based upon new techniques in the field of automation.

Aetna Life and Casualty developed a system which included standardized computer programs, systems and clerical documentation, and operating instructions for its own use. During FY 1973, two of Aetna's field offices implemented this system, bringing the total number of users to three. In accordance with SSA's plan to assume responsibility for maintenance and further development of the Aetna System, International Telephone and Telegraph Company was selected in February 1973 as the contractor to perform these services.

The cost of developing and implementing both of these Medicare systems are borne by SSA. The programs, documentation, and specifications for these computer systems are available to any Medicare contractor or potential user of the system. The benefits to the Medicare program are significantly reduced systems maintenance cost and improved processing quality.

Part B Model System

During FY 1973, the Part B Model System was installed in eight additional carrier locations, bringing the total number of users to 27. Of the new sites, two are using the on-line option. Two other carriers were converted from the batch to the on-line version. These new carriers will add approximately 4,800,000 processed claims to the total processed for FY 1974, and have reduced the average cost per claim for all Model System carriers.

Maintenance of the computer programs comprising the Part B Model System operating in a batch mode has been brought in-house, as has the maintenance and operation of the programs for acceptance testing of the Model System. This latter step eliminated two prior subcontracts, which cost approximately $1,000,000 in 1972.

Health Insurance Beneficiary State Tape

The Health Insurance Beneficiary State Tape (BEST), an alphabetic computer magnetic tape of all Medicare beneficiaries, sequenced in State order, was developed and distributed to 34 selected carriers and intermediaries in November 1973. Carriers and intermediaries will use it to pre-screen and automate their search of beneficiary surnames and claim numbers in claims processing.

Uniform Claim Form for all Third-Party Payers of Medical Services

Under the auspices of the AMA, a work group representing Blue Shield, Commercial Health Insurance Carriers, and all Federal agencies engaged in health insurance programs developed a common form for reporting medical services. As use of the new form becomes widespread in any Medicare carrier's area, Medicare claims will be accepted on the new form. Use of the new form will lessen the impact on the medical profession in completing insurance forms because the items of data and the format are uniform for all types of third-party payers.

Administrative Costs of Contractor Operations

The costs of intermediary and carrier operations are monitored through the budget process. Claims workload estimates form the core of this process. Intermediaries and carriers are required to submit detailed justifications with their annual budget estimates which sufficiently explain the proposed use of requested funds. Items of possible expenditure must be fully explained, and are considered in the light of estimated annual workloads and productivity.

After analysis of this data, intermediaries and carriers are granted annual budgets which are apportioned on a quarterly basis. They are required to plan their operations within the limits of these allocations. Budgetary overruns are not compensated by SSA unless they have been justified and written authorization is granted.

Each intermediary and carrier is required to submit quarterly cost statements and a final annual cost report based on its accounting year. The quarterly reports reflect actual administrative costs broken down by functions performed, as well as total benefits paid and workloads processed during the reporting period. The reports are reviewed from the standpoints of manpower use, productivity, cost per claim, and the ratio of administrative costs to benefit payments. Significant deviations of incurred costs from the budget as originally approved must be explained.

The final annual cost reports form the basis for audit and final cost settlement each year, and are much more detailed. In addition to the information contained in the quarterly reports, a detailed justification of proposed expenditures similar to that required for budget estimates must be submitted. All pertinent information becomes part of the contract reporting and monitoring system used to coordinate the entire claims processing system.

Administrative costs for Part A intermediaries increased from $110,128,500 in 1972 to $141,214,200 in 1973. Most of this increase was attributable to a 7.2% increase in bills processed over 1972. The remainder is attributable to salary and other price increases, continuing emphasis on quality review, and implementation of new data processing systems.

Administrative costs for Part B carriers increased from $171,765,600 in 1972 to $187,228,700 in 1973. The cost increase was due to large workloads, salary and other price increases, improved claims review processes, and implementation of new processing systems.

Total administrative costs for 1973 were quite reasonable when measured as a percentage of benefit payments. The ratio of administrative costs to benefit payments for Part B exceeds the same ratio for Part A because of the large volume of claims involving relatively small payments under the medical insurance program.

DIRECT REIMBURSEMENT

The Division of Direct Reimbursement (DDR) of the Bureau of Health Insurance, acts as intermediary for those institutional providers that have elected to have payment made directly by the Government. Nationally, direct dealing providers represent about 3 percent of all participating providers, and are dispersed throughout 35 States, the District of Columbia, and Puerto Rico. Every type of eligible participating institution is represented. Approximately 80 percent of the institutions are State-or municipally-controlled. Additionally, over 400 Department of Defense, Public Health Service and Veterans Administration hospitals submit claims for the emergency services that they occasionally furnish to Medicare beneficiaries.

During FY 1973, a decision was made to have DDR reimburse all free-standing, physician-directed, Federally funded comprehensive health centers for covered services rendered to Medicare beneficiaries. By the end of the fiscal year, 151 such centers had been identified and most were submitting bills for covered services. By the end of fiscal year 1973, the Division had processed over 20,000 such bills.

In May 1973, SSA began working with the Community Health Service in developing plans for a demonstration program providing inpatient hospital services to migrant farm workers and their families. Under this program, which is being financed by a $3 million grant from the Bureau of Community Health Services, some 50,000 domestic migrant farm workers and their families will have hospital services made available to them. Coverage guidelines and a benefit package have been developed and the system for processing billings and reimbursing hospitals and physicians for services to migrants has been designed.

During the year, there was an increasing transition towards an automated system of claims processing. A Provider Appeals Section was established to implement a provision of the 1972 law which accorded Medicare providers the right to appeal an intermediary's final reasonable cost determination. During FY 1973, the Section began processing provider appeals while developing comprehensive procedures needed to implement this provision. The Division also established the capability needed to reconsider appeals filed by beneficiaries who are dissatisfied with coverage decisions made with regard to Part A services. This activity is being carried out by a Reconsideration Staff established because of an administrative decision to assign to each intermediary responsibility for conducting its own reconsiderations.

DIRECT DEALING PROVIDERS

		TOTAL
HOSPITALS		187
Short Term	109	
Long Term	8	
Tuberculosis	7	
Psychiatric	63	
SKILLED NURSING FACILITIES		86
HOME HEALTH AGENCIES		357
OUTPATIENT PHYSICAL THERAPY PROVIDERS		3
TOTAL		633
FEDERAL EMERGENCY HOSPITALS		418
COMPREHENSIVE HEALTH CENTERS		151
GRAND TOTAL		1,202

Roughly 1.5 percent of the national Part A claims workload is submitted by direct dealing providers. A total of 870,491 bills were processed in FY 1973 with total benefit payments of $146.9 million.

Part II - MAINTAINING HEALTH AND SAFETY STANDARDS IN MEDICARE PARTICIPATING FACILITIES

During fiscal year 1973, efforts were intensified throughout the Department of Health, Education, and Welfare to assure that participating providers in the Medicare program met the health and safety standards required by the law and implementing regulations. Among the steps taken by HEW to improve the surveillance process were the establishment of the Office of Nursing Home Affairs to act as the central policy organization for all long term care facilities; the redelegation of authority for the certification of skilled nursing facilities to the HEW regional directors; the promulgation of common Medicare/Medicaid health and safety regulations for skilled nursing facilities; and an overall effort to regionalize as many of the standards enforcement responsibilities as possible. Regulations pertaining to the certification or recertification of providers were streamlined, and there was a significant increase in onsite surveys of providers. Particular emphasis was placed on fire safety enforcement.

Increased Inspections of Medicare Facilities

Contracts are made with State health departments to inspect health care institutions desiring to participate in the Medicare program. 1/ The health departments determine whether the institutions meet the program's health and safety requirements and other conditions of participation. HEW and SSA regional staffs evaluate the State agency findings and recommendations, relating to their participation in the Medicare program.

From the beginning of the Medicare program through fiscal year 1972, hospitals, skilled nursing facilities, and home health agencies participating in Medicare were surveyed every 24, 18, or 12 months depending on the level of their certification. However, beginning with FY 1973, all hospitals, skilled nursing facilities, and home health agencies were surveyed annually, irrespective of their level of certification. This change in the time frame for resurveying providers caused a part of the overall increase of 11% in the number of formal surveys in FY 1973. The remainder of this increase was brought about by an increase in the total number of providers, changes of ownership, and more frequent inspections of those facilities having deficiencies.

In addition to formal surveys, State agencies conducted 14 percent more "other purpose" visits in FY 1973 than in FY 1972; 2,800 such visits were conducted by State agency staff in FY 1973. "Other purpose" visits include follow-up visits to all classes of providers to check on correction of deficiencies, to investigate complaints, and to make unannounced visits. Unannounced visits are made to assure that conditions found during scheduled visits are truly representative of the facility's ongoing operation.

In FY 1974, substantial increases are expected in the number of State agency "other purpose" visits to implement provisions calling for public disclosure of deficiencies and the annually renewable participation agreements for skilled nursing facilities. To accommodate the increased workload in FY 1974, a budget of $19,850,000 was made available to the State agencies.

1/ A list of contracting State agencies appears in Appendix D, Exhibit 1.

State Agency Surveyor Training

During FY 1973, 498 State surveyors attended a 4-week university-based training course sponsored by the Public Health Service and the Social Security Administration designed to improve surveyor skills and techniques. These 4-week courses were held at U.C.L.A., the University of Maryland, the University of Colorado, and Tulane University. During the fiscal year, the program at Tulane University was expanded to include a 2-week advanced course for graduates of the basic course. In addition, a 2-week course for State agency program supervisors was established at the University of Oklahoma. Thirty-one State agency surveyors attended the advanced course and 98 State agency program supervisors attended the supervisory course during the fiscal year.

Monitoring of State Agency Performance

The monitoring of State agencies to evaluate their proficiency in provider inspection is accomplished primarily through periodic onsite program reviews conducted by Federal teams. An important feature of these reviews is the direct Federal surveys of a number of providers in each State to ascertain whether the State surveyors are properly applying regulations and identifying deficiencies.

In FY 1973, there were 25 comprehensive program reviews, with 104 surveys of health facilities done in conjunction with these reviews. In addition, approximately 200 other Federal State agency surveys were accomplished by SSA during the year. In visiting the States during the past year, emphasis was also placed in the manner in which State agencies were organized and staffed to carry out the provisions of P.L. 92-603. This was of particular importance in the preparation of a list of provider deficiencies for public disclosure and for time-limited agreements not to exceed 1 year for skilled nursing facilities.

Life Safety Code Implementation

In October 1971, SSA adopted by regulation the Life Safety Code (LSC) (1967, 21st edition) as the fire safety requirement for institutional health care facilities (hospitals and nursing homes) participating in the Medicare program. The LSC is a publication of fire safety standards developed by the National Fire Protection Association (NFPA). Throughout FY 1972, despite BHI efforts, there was considerable misinterpretation by the States of the LSC. During FY 1973, BHI undertook an intensive Life Safety Code training program, through State agency policy issuances, in an effort to reemphasize and clarify previously promulgated Medicare fire safety regulations.

In July 1972 a contract was signed with the NFPA. This resulted in three 4-day seminars held in Boston, Chicago, and San Francisco in September and October 1972. In addition, training sessions dealing with LSC

survey form completion and documentation were held in all 10 DHEW regions during May and June of 1973.

In July 1972, SSA arranged for DHEW's Facilities and Engineering Construction Agency (FECA) to provide the States with needed technical assistance in the interpretation of the LSC as well as the actual surveying of facilities where necessary.

Guidelines for the implementation and enforcement of the LSC have been issued to all State survey agencies. In most States, subagreements have been signed with either the State Fire Marshal or the Hill-Burton agencies of the State health units to perform LSC inspections. A one hundred percent review of all LSC reports is continuing.

Development of Certification Data Retention System

In FY 1973, work was completed on an automated system designed to review all incoming survey report forms on health providers and independent laboratories participating in Medicare. The system will also collect data on such facilities for evaluation of compliance with the conditions of participation (and conditions for coverage in the case of independent laboratories), and for various management analysis purposes such as monitoring State agency performance in carrying out their survey and certification responsibilities. Data on compliance or noncompliance with regulations on all providers and independent laboratories is now available in the data base and will be updated as recertifications are processed.

Public Disclosure of Provider Deficiencies

To provide information about provider deficiencies for public scrutiny, deficiency information is now put on file for public inspection at SSA district offices and at State public assistance offices. This information consists of the State agency reports concerning deficiencies cited during surveys, and the providers' plans of correction, rebuttals, or other responses to the cited findings. This information is made public without any effort to editorialize or interpret it.

PART III - PROVIDER REIMBURSEMENT

The principles and procedures governing Medicare reimbursement to providers of health care services were, under statutory direction, adapted from the generally accepted practices of public and private third-party payers with experience in cost reimbursement for health care services.

Medicare reimbursement of the reasonable costs participating hospitals, skilled nursing facilities, home health agencies, and outpatient physical therapy facilities incur in furnishing covered services to program beneficiaries includes all necessary and proper, direct and indirect, expenses incurred by the providers in the production and delivery of quality patient care. In the context of a health care system where the actual costs of delivering patient care vary widely from one provider to another due to differences in provider size, level of care, scope and utilization of services, geographic location, and other factors not necessarily related to the degree of efficiency and economy practiced by the providers, reasonable cost reimbursement is intended generally to meet the actual costs incurred by a provider in rendering patient care.

Limitations on the recognition of incurred costs for Medicare reimbursement purposes to the extent such costs are unreasonable or substantially out of line with the costs of comparable providers in the same area have been difficult to apply effectively. Moreover, the disallowance of costs after they have been incurred creates financial uncertainty for providers, with resulting problems in administrative planning. Thus, it has generally been recognized that Medicare reimbursement on the basis of incurred costs has not offered adequate incentives for the provider efficiency and economy needed to help stem the rapid inflation of health care costs. However, during FY 1973, a number of administrative steps were taken to improve the reimbursement process, both in terms of greater reliability in provider reporting as well as in terms of greater equity for the Medicare program in determinations of allowability for certain costs and in the disbursement of funds under procedures that minimize loss of interest income to the Government.

Of even greater significance in FY 1973, however, were the cost control measures enacted as part of P.L. 92-603, the Social Security Amendments of 1972. These measures, described later in this section, have great potential for restraining provider cost escalations which are not consistent with efficient and economical utilization of patient care resources.

In FY 1973, Medicare also continued to provide program support to the implementation of the President's Economic Stabilization Program which places limitations on the allowability of price increases by health care providers. Because cost reimbursement under Medicare and other Government

health insurance programs has been defined as prices for this purpose, SSA issued instructions to intermediaries which established a presumptive compliance/referral system between Medicare and the economic stabilization authorities. Under this system, reimbursement otherwise due the provider but in excess of the levels that could be presumed to be in compliance with economic stabilization rules was withheld while the provider was referred to the economic stabilization authorities for an evaluation of compliance.1/

ADMINISTRATIVE IMPROVEMENTS IN PROVIDER REIMBURSEMENT POLICY

During fiscal 1973, BHI continued through administrative action to make progress in refining the policies and procedures governing Medicare provider reimbursement in an effort to obtain better reasonable cost determinations and improve payment mechanisms. Some of the more significant steps taken are discussed below:

Provider Recordkeeping Capability and Fiscal Responsibility

In some instances, providers entered the Medicare program without adequate financial records, which made it difficult to prepare accurate cost reports and to determine reasonable cost. To protect the program against such situations, regulations related to the recordkeeping capability of Medicare providers were published in the Federal Register on March 9, 1973. The regulations require intermediaries to determine whether a newly certified provider has adequate recordkeeping capability for determining the cost of services furnished program beneficiaries before making payments to the provider and to suspend Medicare payments at any time it ascertains that a provider's records are no longer adequate. Also, the Secretary may not enter into a provider agreement with any organization which has been adjudged insolvent or bankrupt under appropriate State or Federal law or with respect to which a court proceeding to make such judgment is pending.

Provider Cost Report Filing Requirements

Regulations establishing provider filing requirements for cost reports were published in the Federal Register on October 13, 1972. The regulations require providers to file cost reports on or before the last day of the third month following the close of the period covered by the report, with a 30-day extension for good cause. A provider which voluntarily or involuntarily ceases to participate in the program or experiences a change of ownership is required to file a cost report no later than 45 days after the official date of termination or change of ownership.

Provider Cost Reporting Forms

Work was underway in fiscal 1973 on complete revision of all the provider cost reporting forms. The revised forms will reflect the provisions of

1/ With the abolishment of the Economic Stabilization Program on April 30, 1974, this procedure was terminated.

the regulations on cost apportionment published in the Federal Register on May 20, 1972, which (1) eliminated the option which providers previously had between the two methods of cost apportionment, (2) provided for simplified cost-finding procedures for providers required to use the Combination Method of cost apportionment, (3) revised the Departmental Method of cost apportionment to require apportionment of routine service costs on an average cost per diem basis, (4) provided for separate apportionment of the routine costs of the special care units, (5) provided for exclusion of delivery room costs from the computation of reimbursable cost under the Combination Method as well as the Departmental Method, and (6) specifically provided for the non-recognition of luxury items or services. In addition, the revised forms will reflect those provisions of the Social Security Amendments of 1972, which have cost reporting implications.

Recovery of Accelerated Depreciation and Gains and Losses on Disposal of Depreciable Assets

After extensive consultation with interested outside parties, instructions were developed during fiscal 1973 to more effectively implement a prior regulatory provision requiring program recovery of excess depreciation where a provider using an accelerated depreciation method terminates or substantially reduces its level of participation in the program after the years of highest accelerated depreciation allowances. The instructions also clarify the treatment of gains or losses on the disposition of depreciable assets by providers.

Reasonable Cost of Drugs Purchased Under Arrangements

Implicit in the statutory provision that only a provider's reasonable costs be paid is the expectation that the provider will be a prudent and cost-conscious buyer by not only refusing to pay more than the "going price" for the supplies and services it purchases for the production and delivery of patient care but also by seeking to minimize its costs to the extent feasible. Costs determined to be in excess of what prudent and cost-conscious buyers pay for a given item or service are not reimbursable. While this "prudent buyer" policy is applicable to all supplies and services used by providers, the initial emphasis in implementing the policy has been on those ancillary services and supplies purchased by providers from outside suppliers and for which Medicare reimbursement is significant. One area of special concern, for example, has been providers' costs for drugs and related medical supplies purchased from retail outlets by providers not having their own pharmacies. During fiscal 1973, instructions were issued establishing a uniform approach in estimating the "going prices" of prescriptions purchased by a provider under arrangements with an outside pharmacy. Guidelines reflect the most recent drug price data for a large number of drug products and provide a methodology for evaluating a provider's costs for drugs (or drug strengths or forms) not covered by the drug price data.

Home Office Costs of Chain Organizations

Since the beginning of the Medicare program, a large number of chain organizations of providers have developed, creating special problems in the recognition of costs for reimbursement under the program. During fiscal 1973, SSA issued instructions defining costs which are allowable and those which are not allowable under the program, and prescribing methods for computing allowable costs. In addition, SSA issued instructions on audits of home office costs of chain organizations. The instructions require the designation of one intermediary to be responsible for audit when more than one intermediary services providers in a chain. This provides a more systematic approach to chain audits and prevents duplicate work where multiple intermediaries are involved.

Elimination of Current Financing Payments

At the outset of the Medicare program, many providers feared there might be procedural delays in receiving reimbursement for services covered by the program. To alleviate this concern, SSA established a special payment mechanism under which a provider could receive "current financing payments," designed to compensate for possible lags in payment on individual bills. However, the claims reimbursement process has now become so well established that interim payments are being made on a prompt and regular basis, so that there no longer is a need for the special current financing device. Moreover, current financing payments were producing a cash flow that inappropriately placed substantial Medicare funds with providers even in advance of actual expenditures, with a resultant loss of interest income to the Medicare trust funds. Therefore, the regulations authorizing current financing payments were rescinded on May 29, 1973, and providers were required to repay outstanding current financing payments by May 29, 1974, except where an extended recovery period would be warranted due to financial hardship.

STATUTORY IMPROVEMENTS IN PROVIDER REIMBURSEMENT POLICY

While administrative improvements under the law in effect at the beginning of FY 1973 contributed to increased program effectiveness, there were reimbursement issues that could not be resolved without new statutory authority. With the enactment of P.L. 92-603 on October 30, 1972, the Department's capability to control cost escalation was greatly enhanced. SSA's efforts during fiscal 1973 to implement these important new provisions of the Social Security Amendments of 1972 are discussed below.

Limitation on Coverage of Costs Under Medicare (Section 223)

The Amendments authorize the Secretary to set prospective limits on reasonable costs. This differs from previous authority in that it

permits establishment of prospective ceilings on overall direct or indirect provider costs and also on costs of individual items or groups of services which can be recognized as reasonable on the basis of comparisons of the costs of efficient delivery of covered services by various classes of providers in the same geographical area. The authority is to be exercised on a presumptive basis so that the burden of justifying relatively higher costs as reasonable is shifted to the provider. Since limits are to be defined in advance of the provider cost reporting periods to which they will apply, providers will have the opportunity to act to avoid incurring costs above the acceptable levels. Provision was also made for a provider, after notice to beneficiaries, to charge them for the unreimbursed costs of services (other than emergency care) in excess of, or more expensive than, those found necessary for the efficient delivery of needed health services.

In granting this authority, Congress was aware of the difficulties in setting prospective limits on reasonable cost reimbursement caused by deficiencies in cost data and limitations in current methodologies for comparing provider costs, measuring health care output, and estimating costs necessary for efficient delivery of needed health care. It recognized that the initial ceilings imposed would, thus, of necessity be imprecise and affect a relatively small number of providers. The expectation was, therefore, that cost limits would be put into effect to the extent currently feasible and refined and extended as developing cost data and methodology permit.

SSA worked during fiscal 1973 to develop regulations and cost limits to implement this section of the law. Within the limitations of the available data, it was possible initially to develop only a relatively simple system of classifying providers first by SMSA (Standard Metropolitan Statistical Area) or non-SMSA location in States, then making five classes of each of these based on per-capita income, and then in the case of hospitals, dividing each of the resulting ten geographic classes into seven additional categories based on bed capacity. Pending the development of a provider classification system capable of taking account of differences such as nature and scope of services provided and types of patients treated so that cost limits will not result in disallowance of costs necessary for the delivery of needed services as well as costs arising from inefficiency of operation or conditions of excessive service, the proposed approach will place limits initially only on hospital costs for general routine services. In recognition of the data base limitations and the Congressional intent that initially few providers would be subject to the limits, the initial limits were set at levels high enough--90th percentile of routine costs experienced by the comparison group plus an add-on of 10 percent of the median for each group--to allow wide variations from average costs of the comparison group. The basic data for setting limits on general routine service costs was derived from the average per diem cost for each hospital as reflected in its interim rate of reimbursement. This data was collected during fiscal 1973, and regulations prescribing hospital cost limits were drafted.2/

2/ Final regulations were published in the Federal Register on June 6, 1974.

Work on the development of cost limits for skilled nursing facilities and home health agencies was also underway by the end of the fiscal year.

Amount of Payment Where Customary Charges for Services Furnished are Less than Reasonable Cost (Section 233)

Believing it to be inequitable for the Medicare program to pay providers more on behalf of the beneficiary than a beneficiary would himself have to pay for his care on a charge basis, Congress also provided in the 1972 Amendments that Medicare reimbursement for services in provider cost reporting periods beginning after 1972, should be the lesser of the reasonable cost of the services or the provider's customary charges to the general public for such services. However, Congress provided for an exception where such services are furnished by a public provider free or at nominal charges to the public. In such cases the provider is to be reimbursed "fair compensation" not to exceed reasonable cost.

Regulations to implement this important provision were developed during fiscal 1973. However, since the ability of providers to gauge the effect of the provision on their operations depended upon the regulations resolving those issues which the statute left to administrative discretion, for example, the definitions of "customary charges," "public providers," "nominal charges," and "fair compensation," and since providers were inhibited by economic stabilization rules from raising their charges to the level of cost in order to avoid financial hardship from the application of the lower of cost or charges limitation, Congress included in P.L. 93-233 a technical amendment delaying application of the provision to cost reporting periods beginning after 1973.3/

Reasonable Cost of Therapy Services Furnished Under Arrangements (Section 251(c))

Considerable effort and consultation with interested outside parties was undertaken in fiscal 1973 to implement another provision of the Amendments directed at controlling program expenditures and preventing abuses. This provision requires the Medicare program to establish criteria and guidelines for determining the reasonable cost of physical and other therapy services furnished by providers under arrangements with outside suppliers. Payment to the provider for such services is to be limited to amounts equivalent to the salary and other costs that would have been incurred by the provider if the services had been performed in an employment relationship, plus an allowance to compensate for other costs an individual not working as an employee might have, such as maintaining an office, travel expenses, and other costs. However, payment may be made on the basis of a reasonable rate per unit of

3/ Final regulations were published in the Federal Register on May 10, 1974.

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service, where the services of a therapist are required only on a limited part-time basis or only intermittently and where aggregate reimbursement on this basis is less than would have been paid if the provider had employed a therapist on a full-time or regular part-time basis. The regulations[4/] that have been drafted to implement this provision would be applicable to all therapy services furnished by providers under arrangements but actual implementation will be achieved by the issuance of separate guidelines establishing salary equivalents by geographic area, which will be different for each type of therapy. Initial efforts in this area are being concentrated on physical therapy which is the most frequent therapy service furnished under arrangements. Until additional guidelines are developed, other therapy services will continue to be evaluated under Medicare's prudent buyer policy.

Limitation on Federal Participation for Capital Expenditures (Section 221)

The Bureau of Health Insurance worked closely during fiscal 1973 with the Department's Comprehensive Health Planning Service to implement another provision of the Amendments which authorizes the Secretary to withhold or reduce Medicare reimbursement to a provider for depreciation, interest, and in the case of proprietary providers, a return on equity capital, and other expenses related to capital expenditures for plant and equipment which (1) exceed $100,000, (2) change the bed capacity of the facility, or (3) substantially change the services provided by the facility and which are determined to be inconsistent with State or local health facility plans.

4/ The regulations will reflect the provision in P.L. 93-233, enacted December 31, 1973, that reimbursement under this provision shall be effective only for provider accounting periods beginning after the date of publication of final regulations. The original provision in the 1972 Amendments had provided for effectuation with accounting periods beginning after December 31, 1972. The technical amendment was considered necessary in order to avoid adverse fiscal effects on providers who had entered into non-conforming arrangements prior to the publication of regulations.

PART IV - REIMBURSEMENT FOR PHYSICIANS' SERVICES

Physicians' services are reimbursed under Part B of Medicare on the basis of reasonable charges. These are determined by taking into consideration a physician's customary charges for a given service and the prevailing charges among physicians in the locality for similar services. Prevailing charges set the outer limit on Medicare reasonable charge reimbursement subject only to the further limitation that reasonable charges may not exceed the charges applicable for similar services and under comparable circumstances to the policyholders and subscribers of the carrier. To a great extent, therefore, Medicare reasonable charge reimbursement is responsive to the fee-charging patterns of the medical community.

Beginning in 1971, all carriers have been required (1) to use charge data derived from the immediately preceding calendar year when they update their fee screens for a new fiscal year; (2) to use the median of a physician's charges for a service as his customary charge for that service; and (3) to calculate the 75th percentile of the customary charges in the locality as the prevailing charge ceiling for a given service. These policies were incorporated into the law by the 1972 amendments to the Social Security Act (P.L. 92-603) which provided that for bills submitted after December 31, 1970, prevailing charge levels may not exceed the 75th percentile of customary charges in a locality for similar services during the calendar year prior to the start of the fiscal year in which the bill is submitted. The amendments also provided that for fiscal years beginning July 1, 1973, and thereafter, the prevailing charge levels recognized in a locality with respect to physicians' services may not be increased in the aggregate over the previous fiscal year's prevailing charge levels, except to the extent justified by economic indexes reflecting changes in costs of practice of physicians and in earnings levels. The economic index provision was not generally implemented for fiscal year 1974 since Medicare fee screen increases were limited by more stringent economic stabilization controls than the index would have imposed.

Implementation of President's Economic Stabilization Program 1/

Reasonable charges allowable under Medicare are updated for each fiscal year (beginning July 1) based on the charges physicians and suppliers have billed for covered services in the immediately preceding calendar year. However, for fiscal years 1973 and 1974, the aggregate increases allowed in Medicare fee screens have been limited to 2 1/2 percent per year pursuant to rulings by the Price Commission and the Cost of Living Council. In addition, the actual updating of Medicare carriers' fee screens which had been scheduled for July 1973 was delayed until after August 12, 1973, because of the 60-day freeze on price increases imposed by the President in June 1973.

1/ With the termination of the Economic Stabilization Program on April 30, 1974, these procedures will no longer be effective.

Our instructions to the carriers have also provided for the reporting of possible violations of limitations on physician fee increases under the economic stabilization program, and that where a price increase was made contrary to the Price Commission's or Cost of Living Council's regulations, the charge may not be used in calculating new Medicare fee screens.

Procedural Terminology and Coding

Efforts to develop a uniform system of procedural terminology and coding for use under the various health care related programs administered by the Department were continued in fiscal year 1973. As a first step, the Health Services Administration carried out a preliminary field test of a possible new system for describing physician visits, since they constitute the service rendered most frequently by physicians. A further cost/benefit study of the proposed system is being planned. In addition, new regulations have been developed recently to provide guidelines for use by the Department in evaluating carriers' requests to change the systems of procedural terminology and coding currently used in their Medicare operations. Since the guidelines were designed to assure that changes in carriers' procedural terminology and coding systems are made only where the advantages of the new system outweigh any potential disadvantages, such changes may be made only where they will result in more efficient and economical determinations with respect to Medicare coverage and reimbursement.

Teaching Physicians

Section 227 of Public Law 92-603 significantly changed Medicare coverage and reimbursement for physicians' professional services rendered in teaching hospitals. Essentially, section 227 provided that reasonable charges would be payable for physicians' services rendered in teaching hospitals only where the patient was a "private patient." Where the patient was not a private patient, section 227 provided for more favorable reasonable cost reimbursement than under prior law (i.e., cost payment for physicians' professional services to hospital inpatients would not be subject to the deductible and coinsurance provisions generally applicable to physicians services; payment of certain medical school costs relating to the provision of services in the hospital by faculty members; cost payment for the professional services of unpaid voluntary physician staff on a salary equivalent basis). In preparation for the implementation date, i.e., hospital cost accounting periods beginning after June 30, 1973, a series of meetings were held with the Association of American Medical Colleges to ascertain the problems of teaching hospitals and medical schools and to get an idea of the potential impact on the health care delivery system in teaching hospitals and medical centers. There was also consultation with other professional organizations such as the American College of Radiology and with Medicare

carriers and intermediaries. In addition to revised regulations, manual instructions were prepared and sent to the Medicare intermediaries and carriers, as well as to hospitals.

The regulations which were published in the Federal Register in proposed form on July 19, 1973, received extensive and, in many instances, critical comment from over 100 interested parties, including the American Medical Association, the American Hospital Association, and the Association of American Medical Colleges. Subsequently, Congress enacted P.L. 93-233 (December 31, 1973) and P.L. 93-368 (August 7, 1974) providing that implementation of section 227 be delayed pending a report by the Secretary of Health, Education, and Welfare to the Congress of the results of a study to be conducted by the National Academy of Sciences. 2/ The study will analyze appropriate and equitable methods of payment for physician services under Medicare and Medicaid, the extent to which funds expended under these programs support training of medical specialties in excess supply, how expenditure of such funds could aid in better distribution of physician manpower, the extent to which such funds support or encourage programs which disproportionately attract foreign medical graduates and the extent to which such funds are, and should be, expended to meet in whole or in part the cost of salaries of interns and residents in approved teaching programs.

2/ Under P.L. 93-368, implementation is delayed to provider cost reporting periods beginning after June 30, 1976. P.L. 93-233 provides that a hospital may elect the more favorable cost reimbursement for physicians' services provided by P.L. 92-603 without waiting for the results of the study. This means that if a teaching hospital and its physicians do not elect to be reimbursed on the new cost basis, program reimbursement for physicians' services rendered in the teaching hospital may continue to be made under the criteria in effect prior to P.L. 92-603.

PART V - REIMBURSEMENT OF HEALTH MAINTENANCE ORGANIZATIONS

Section 226 of the Social Security Amendments of 1972 (Public Law 92-603) provided for Medicare reimbursement to Health Maintenance Organizations (HMOs). Under prior law, group practice prepayment plans providing comprehensive health services on a prepaid capitation basis could not be reimbursed by Medicare through a capitation rate which would constitute a single payment for all covered services furnished to their beneficiary enrollees. Instead, prepayment plans could be paid under Medicare on the basis of their costs of providing physicians' and related services under Part B. Reimbursement for inpatient care in a hospital or for extended care services or home health services was made separately on a cost basis to the actual provider of the services. The financial incentives which these organizations have in their regular business to keep costs low and control utilization did not, therefore, fully apply with respect to their Medicare enrollees.

Beginning July 1973, two new methods of reimbursement--incentive reimbursement and cost reimbursement--both involving a single reimbursement for services covered under Medicare and provided to the organization's Medicare enrollees, will be available to qualified organizations. Under the incentive reimbursement option, which would be available only to well-established HMOs that meet the full statutory definition of an HMO as well as other requirements, the HMO would be at risk for the services it provides to its Medicare enrollees. The HMO would share with the Medicare program the "savings" when the HMO provides services to Medicare beneficiaries at a lower per capita cost than would have been incurred if the services had been provided outside the HMO. Under the cost reimbursement option, intended primarily for new HMOs, the organization would not be at risk, but would be paid the full reasonable costs it incurred in providing covered services to its Medicare beneficiaries. One purpose of the cost reimbursement option is to protect new HMOs from incurring losses with respect to their Medicare enrollees during their initial years of operation when start-up costs are high, enrollment has not yet stabilized, and it is very difficult to develop accurate actuarial estimates of expected costs and utilization.

While group practice prepayment plans are one major type of organization that could qualify to be reimbursed under Medicare as an HMO, the new law also encourages a variety of other organizational arrangements to seek qualification as HMOs.

During fiscal year 1973, SSA efforts in regard to the reimbursement of Health Maintenance Organizations (HMOs) were centered on developing qualifications which an organization must meet to be eligible to enter a contract with Medicare as an HMO. SSA also developed an application form which would elicit information necessary to allow preliminary review of the organization's ability to provide covered services promptly, appropriately, and with assurance of acceptable quality.

This application was mailed in 1973 to approximately 285 organizations which had expressed an interest in participating as HMOs. 1/

1/ As of the end of 1973, completed applications had been received from 16 organizations which appears to have potential for being eligible for an HMO Medicare contract. With the passage of the "Health Maintenance Organization Act of 1973," which was signed by the President on January 2, 1974, substantial funding for HMO development will be made available through Public Health Service grants. It is expected that this will stimulate an increase in interest toward Medicare participation.

PART VI - THE APPEALS PROCESS

Beneficiary Appeals

Section 1869 of the Medicare law provides appeal rights for a beneficiary who is dissatisfied with the determination of his entitlement under Part A, his enrollment under Part B, or the amount of benefits due him under Part A. Any beneficiary who questions the initial determination made on his hospital insurance claim may request that the decision be reconsidered. If he is not satisfied with the reconsideration decision and the amount in question is at least $100, he may request a hearing before an administrative law judge of SSA's Bureau of Hearings and Appeals and a subsequent review by the Appeals Council. After exhausting these administrative appeal mechanisms, a claimant may seek judicial review if the amount in question is at least $1,000.

The Part A reconsideration function formerly conducted by a specially trained staff in SSA's Bureau of Health Insurance was transferred to intermediaries effective February 12, 1973. This action was taken after a pilot project involving five intermediaries established that intermediaries had the capability to perform the reconsideration function. It was also determined that considerable duplication of effort would be avoided and that improved speed of processing reconsiderations would result if they were handled by intermediaries. After this transfer, SSA assumed responsiblity for reviewing a scientific sample of completed reconsideration cases. Information gathered from this process is coupled with manpower utilization information in evaluating intermediary performance. A decrease in the number of beneficiary appeals under the hospital insurance program was noted during fiscal year 1973. Part A reconsideration requests received during the fiscal year numbered 28,331, an 8% decrease under the 31,156 received during 1972. There were 6,505 Part A reconsiderations pending at the year's end. The reversal rate was about 26%.

Requests for Part A hearings received during fiscal 1973 decreased to 5,639 from the 6,151 hearing requests received during fiscal year 1972--another 8% decrease. Part A hearings pending as of June 30, 1973, were 3,360; 9% less than at the end of the preceding year. The reversal rate was about 48%.

At this time, reliable data is unavailable as to the impact of section 1879 (Limitation on Liability of Beneficiary where Medicare Claims are Disallowed) on the Medicare appeals process. However, it appears that the reduction in beneficiary appeals is a result of the application of this provision.

During the past 5 fiscal years, the Appeals Council has reviewed an increasing number of administrative law judges' decisions (formerly called hearing examiners). The number in fiscal 1969 was 130; in

fiscal 1970, 373; in fiscal 1971, 702; in fiscal 1972, 1,034; and in fiscal 1973, 1,325.

Section 1842 of the Medicare law provides that the entire claims appeals process in the medical insurance program is to be handled by the carrier. A beneficiary who questions an adverse initial decision made by a carrier may ask an informal review of the claim, and if the result of that review is not satisfactory a formal hearing by the carrier's hearing officer may be requested if the amount at issue is $100 or more. The law provides for no appeal from the carrier's decisions to SSA or to the courts.

Under Part B, there were 557,910 requests for review, a 0.7% increase over fiscal year 1972. Pending at the year's end were 41,340 cases, an 86.7% increase over the pending for the prior year. The reversal rate for reviews is 56.3%.

Requests for Part B hearings received during fiscal 1973 increased to 8,342, a 4.6% increase over 1971, far less than the 66.5% increase the preceding year. This diminished percentage increase for fiscal 1973 is due in large part to the imposition of the $100 limitation on the amount in controversy to qualify for a hearing. Hearings pending as of June 30, 1973, were 1,239, 57% less than at the end of the preceding year, probably due to increased proficiency at the carrier and hearing level.

Of all requests for Part B hearings processed, the reversal rate was 26.6%, as opposed to 22% for the previous fiscal year.

In order to increase the proficiency of hearing officers, the Bureau of Health Insurance has set up a formal training program encompassing both substantive and procedural policy, as well as a claims system approach to the Part B claim. It is felt that the hearing process will benefit greatly from this training directed at new hearing officers. The training will continue to stress the importance of due process in the administrative hearing process.

Provider Appeals

Section 1879 of the Act (Limitation on Liability of Beneficiary and Provider) gives providers the right to challenge an intermediary's decision (effective with claims for services rendered after October 30, 1972) through the same appeals process available to beneficiaries under the Part A program. Under this provision, a provider may initiate the reconsideration or, on beneficiary appeal, be made a party if the initial determination is that (1) services were not covered because they were not reasonable or necessary or were custodial; and (2) either the beneficiary or the provider knew or could reasonably have been expected to know that such services were not covered.

Provider Reimbursement Appeals

Under regulations issued in May 1972, a provider dissatisfied with the intermediary's reimbursement determination may appeal to the intermediary and obtain a hearing. Approximately 100 requests for hearing have been filed with commercial intermediaries, while at least an equal number have been filed with the Blue Cross Association. On March 4, 1974, proposed revised regulations were published which eliminated the requirement for a hearing by the intermediary in disputed cost reports for accounting periods ending on or after June 30, 1973, where the amount in controversy is $10,000 or more. This permits the provider to file an appeal directly with the Provider Reimbursement Review Board established by section 243 (h) (new section 1878 of title XVIII) of P.L. 92-603, and under certain conditions, obtain Secretarial and judicial review. The Board is expected to be established and operating by the fall of 1974.

In order to insure that every provider is receiving due process in its appeals, we conducted a formal training session in June 1973 for all intermediary hearing officers, and it is expected that it will be repeated annually. Additionally, the Bureau of Health Insurance reviews all intermediary hearing procedures to determine compliance with the law and regulations and is now monitoring the hearing decisions both through review of the text and by personal observation.

Litigation

Program litigation increased significantly in FY 1973. A total of 171 courts cases were filed, compared to 88 in the preceding fiscal year.

During the year 1972 and through September 30, 1973, SSA received 118 court decisions (110 from district courts and eight from courts of appeal). SSA was affirmed in 35 cases, reversed in 43 cases and 40 cases were dismissed. The largest number of reversals have involved the "level of care" issue where the courts have applied a more liberal view of what constitutes a covered level of care than we have. In Sowell v. Richardson the court held that one must not only consider the treatment immediately required but every aspect of the patient's total physical condition. This was followed by Ridgely v. Secretary in which another court indicated that where there is no conflicting evidence, the patient's physician's opinion is to be given great weight in determining the patient's condition and required level of care. Both of these decisions have apparently had significant influence on other courts and have been frequently cited in subsequent court reversals.

SSA is also beginning to receive a body of adverse court decisions on provider reimbursement disputes. The courts appear to recognize that there is no specific statutory provision under the Social Security Act for judicial review of provider reimbursement disputes. However, it appears that courts may be increasingly willing to assume jurisdiction

have been disposed to assume jurisdiction under cover of the Administrative Procedure Act or, alternatively, under 28 U.S.C. S1331 so long as the requisite $10,000 jurisdictional amount is met. This sympathetic attitude by some courts may help account for the 24 complaints filed in U.S. District Courts from January through September 1973 involving provider cost reimbursement disputes.

PART VII - FRAUD AND ABUSE INVESTIGATIONS

Since the beginning of the Medicare program, the Department has placed great stress on program integrity activities, with the expectation that the combination of an increasingly sophisticated monitoring system and wide publicity within the health field and among beneficiaries, would eventually lead to a reduction in the incidence of fraud and abuse situations. Statistics for FY 1973 suggest that a downward trend in incidence may be beginning.

Total receipts of alleged fraud and abuse[1/] cases for fiscal year 1973 declined by 2590 from fiscal year 1972. Although part of the decline is certainly attributable to greater experience on the part of Social Security district offices, intermediaries, and carriers in recognizing and referring for investigation only the more probable fraud and abuse complaints, we believe that the deterrent effect of publicity about increasing Medicare convictions, indictments, and recoupments may also be reflected in this decline.

Comparison of Medicare Fraud and Abuse Case Receipts - FY 1972 and 1973

	1972	1973	Increase (Decrease)
Total Receipts	7928	5338	(2590)
Fraud	3055	2361	(694)
Abuse	4873	2977	(1896)

Pending workload decreased from a total of 4103 cases at the close of 1972, to 3328 at the end of 1973. These figures represent cases in various stages of development, ranging from initial allegations of fraud or abuse not yet investigated to completed cases containing evidence of intent to defraud the program and those pending with United States Attorneys.

1/ The term abuse is used to describe incidents and practices which, although not fraudulent, may directly or indirectly cause financial losses to the Medicare program or its beneficiaries. Where an abuse situation is identified, actions are taken to prevent recurrences and to recover any overpayment.

Convictions and Indictments

During 1973, there were 40 convictions as compared with 16 in 1972. As of the end of 1973, there were 78 cases pending with United States Attorneys. Of this number, indictments have been obtained or criminal informations filed in 32 cases. Of the 40 convictions in 1973, six were in the hospital insurance program involving hospitals, skilled nursing facilities and home health agencies. These were the first convictions in this area and involved a considerably greater amount of staff time due to the complexities involved in investigations of institutional situations. The other 34 convictions were in the medical insurance program and were almost entirely against physicians.

Civil Fraud

During 1973, our effort in the civil fraud area began to show results. Civil fraud action is taken under the False Claims Act (31 U.S.C. 231). Documentation used to prove criminal fraud is also used to prove civil fraud, and the penalties for civil fraud are added to any criminal penalties and flow from action instituted usually after the criminal aspects have been disposed of.

The great value of proceedings under the False Claims Act lies in the fact that a verdict for the Government under that statute may result in a forfeiture of $2,000 per false claim (plus costs), whether or not the claim was paid, plus double damages if it was. Usually, the total potential forfeiture far exceeds the total amount the Government can readily prove was fraudulently obtained, and thus forms the basis for an equitable negotiated settlement based on an estimate of the total overpayment. This method obviates the reinvestigation of every claim, the cost of which would be prohibitive.

As of the end of 1973, 187 civil fraud cases were pending action with United States Attorneys. Of that number, 98 require criminal disposition before the civil aspects can be considered. In the remaining 89 cases, the criminal aspects have been closed, and only the civil action remains. As of 6/30/73, 32 civil fraud cases had been closed after demand, settlement, negotiation or suit. These 32 cases resulted in a total recoupment under the False Claims Act of $1,596,737.

Physicians with "High Volume" Services

This study began in September 1969 when Senate Finance Committee staff asked for a listing of solo practicing physicians paid more than $25,000 under Part B during the calendar year 1968. BHI continued the study in subsequent years and used it as a means of determining the correctness of payments made to individual physicians with unusual patterns of practice and also to evaluate the controls used by the carriers to assure that proper payments are made. The study conducted in 1973 involved

payments in calendar year 1971. Data for the study were obtained from the payment records the carriers submit to SSA. BHI identified 13,256 numbers, all presumably representing solo practitioners to which carriers paid $25,000 or more in 1971. In addition, the Bureau identified 354 podiatrists who were paid in excess of $9,999 in that year. By applying utilization keys to these numbers, 2,694 cases were identified which required further review.

Repeat physicians appearing on prior reports	160
Podiatrists reimbursed over $10,000	354
Physicians reimbursed over $100,000	285
Physicians failing utilization keys for:	
home visits	292
SNF visits	527
office visits	425
diagnostic services	392
Sample of other physicians earning over $60,000	259
TOTAL	2694

Carriers determined that incorrect payments due to overutilization had occurred in 160 of the cases they reviewed. As of the close of FY 1973, overpayments in the amount of $848,179.13 had been determined in 118 of these cases. At the close of FY 1973, 733 cases were still under review. Additional recoupment of overpayments is likely in a number of these cases.

Comparison of Overpayments Identified and Recovered - FY 1972 and 1973

Year	Amount Overpaid	Amount Recovered
1972	$ 4,176,629.09	$2,473,506.44
1973	10,946,966.40 2/	4,159,095.11 3/
Increase (1973)	$ 6,770,337.31	$1,685,488.67

2/ The striking increase in 1973 outstanding was caused by a single overpayment determination of over $6,000,000 by one region in the last month of fiscal year 1973. This should result in an increase in the "Amount Recovered" category in fiscal year 1974.

3/ Includes recoveries under False Claims Act.

PART VIII - PROGRAM EXPERIMENTATION

The Social Security Amendments of 1967 (P.L. 90-248) authorized the Secretary of the Department of Health, Education, and Welfare to conduct experiments to test the effectiveness of incentives in reducing or retarding increasing program costs without adversely affecting the quality of care. At the close of FY 1973, five incentive reimbursement experiments were in operation and one had just been completed. The provisions of Section 222 of the Social Security Amendments of 1972 (P.L. 92-603) expanded the areas of experimentation in health care financing.

Following is a report on the status of program experimentation activity undertaken by SSA as of June 30, 1973. In addition, the Health Resources Administration engaged in planning for other section 222 areas for which they had the lead responsibility: long-term care; intermediate care; homemaker services; day care services; incidental services; clinical psychologists; and ambulatory surgical centers. 1/

Physician Extender Experimentation

During FY 1973, BHI worked to develop a nationwide test of alternative methods of reimbursing for the services furnished to Medicare beneficiaries by physician extenders employed by fee-for-service physician practice units. It was planned that an outside contractor (or contractors) would be sought through a notice in the Commerce Business Daily for undertaking the development of an overall experimental design and to implement the design on a national scale. 2/

Waiver of the Prior 3-Day Hospital Stay to Qualify for Extended Care Benefits

During FY 1973, BHI developed a research plan to test assertions that program costs are unnecessarily increased by requiring a prior 3-day stay in a hospital before extended care benefits are made available to beneficiaries.

1/ Although the Health Resources Administration had lead responsibility for experimentation with ambulatory surgical centers, an exception was made for the Surgicenter of Phoenix Arizona. Because of SSA's previous contacts with the Surgicenter, they were given the authority to undertake an experiment with that facility. On April 1, 1974, a contract was signed between SSA and the Surgicenter for a 2 year project during which the facility will be reimbursed on a cost basis similar to the method used with hospital outpatient departments under Medicare. Since the services are not covered under the regular program, this will be the first time that Medicare is reimbursing for such costs. The surgeon and anesthesiologist will continue to bill their charges separately under Part B of Medicare.

2/ The RFP for development of the experimental design was published in October 1973 and a contract awarded to Policy Analysis, Inc. The completion of the design is scheduled for early in FY 1975.

Initial priority will be given to conducting a study analyzing the UAW extended care benefit, which has no prior hospitalization requirement. After this study is completed, it is anticipated that experimentation will be conducted waiving the requirement for a limited number of hospital-based SNFs.

Intermediary and Carriers - Fixed Price or Performance Incentive Contracts

During FY 1973, BHI developed an outline for experimentation with fixed price or performance incentive contracts to intermediaries and carriers to determine whether such contracts would produce more effective, efficient, and economical performance.

BHI also developed and negotiated a protocol for the first experiment in this area involving a regional computer center established by four carriers on the basis of a fixed price schedule (MINK: Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County; Illinois Medical Service; Blue Shield of North Dakota; and Kansas Blue Shield). 3/

Prospective Rate Reimbursement Proposal Development

More than 5,000 copies of the Guidelines for Prospective Reimbursement (GPR-1) which set forth criteria that must be met in order to qualify under the program as an experiment or demonstration project, were prepared and distributed. In addition, the Guidelines were available to anyone requesting them and were published in five national health periodicals.

Experimentation programs will be selected so that the broadest possible scope to the research is achieved. The goal will be to carry out experiments using as many different prospective reimbursement methods as possible (i.e., variations on the three basic methods, negotiated rate, formula, and budget review, including controlled charges). Particular interest will be given to how individual systems treat variations in volume and wages, capital financing and budget reviews.

Since each proposal submitted that reaches contract will be unique, contracts will be awarded directly to the sponsoring organization. Three projects have been approved involving selected aspects of prospective rating.

3/ Work on the Regional Computer Center experiment (MINK) has ceased because of the failure of the MINK carriers to reach agreement with SSA on specific terms of the contract.

Also, during FY 1973, the "Perkins Committee" began its review of the entire process of the Government's contracting with Part B carriers. This report was published in July 1974 and we expect that the Committee's report will give impetus to experimentation with fixed price or performance incentive contracts.

In addition to new demonstration projects, onsite reviews are being conducted to determine how a system actually operates and what factors contribute to the success or failure of the system. The major part of this work is being performed by The Harvard University Center for Community Health and Medical Care. Eight such systems were to be reviewed prior to July 1, 1974.

Beyond the analysis of each system, evaluations will be carried out on six with special attention being given to the questions of how such a payment system affects the cost and quality of health care. Each system will be carefully studied by an outside contractor qualified to conduct this type of evaluation.

Ongoing Experiments

Connecticut Hospital Association

This plan was developed by the Connecticut Hospital Association with the cooperation of SSA and Connecticut Blue Cross and applied to all patients covered by Medicare and Blue Cross in the ten hospitals participating as of June 30, 1973. The basic structure of the Connecticut experiment consisted of three peer groups of hospitals which were set up on the basis of number of beds and six Budget Approval Boards which reviewed and approved budgets within their peer groups. The experiment was completed June 30, 1973.

Rewards for the participating hospitals were determined for all 3 years of the experiment, although audits have to be conducted before final payments can be made. The total amount of shared savings was $1,589,000. Of this amount more than $672,000 is represented in savings to the consumer. The remaining $917,000 represents the amount SSA and Connecticut B/C would have otherwise paid for patient care costs.

California (Blue Cross of Southern California - CASH)

Under this experiment, hospital efficiency in a sample of 25 southern California hospitals was measured by comparing actual labor performance with performance standards set by the Commission for Administrative Services in Hospitals (CASH) using industrial engineering techniques.

Reports for hospitals participating in the experiment were determined and are being audited for all 3 years by Blue Cross of Southern California. In the first 2 years of the experiment, $1,237,706 was apparently saved, with $352,250 actually paid as incentives by the Medicare program. Third-year results show that nine of the hospitals will be paid incentives. The experiment results will be evaluated by the Hospital Research and Educational Trust.

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New York

The reimbursement experiment conducted by the Health Insurance Plan of Greater New York (HIP) was designed to try to determine the degree to which a prepaid group practice plan could reduce medical care utilization and costs by special efforts to improve patient management and hospital discharge planning. Evaluation of the HIP experiment is being performed by the Center for Community Health and Medical Care at Harvard University.

Preliminary utilization and cost data were received for incentive calculations for 1970, the first year of the experiment. An interim payment of $750,000 was made to HIP for 1970 based on these data. Available figures for 1969, the year before the experiment, indicated that the per capita reimbursement per year under Medicare for a beneficiary who was an HIP member was higher than that for other beneficiaries living in the same area and receiving care under fee-for-service arrangements--$419.17 per person compared with $391.32, respectively. For 1970, the first year of the experiment, the difference was much smaller--$428.89 per person compared with $423.20. The incentive is to be paid on this improvement. These differentials were accounted for in most part by out-of-plan usage of Part B services. In addition, preliminary data have been received for 1971, indicating that further improvement was made during that year, with total per capita reimbursements of $498.07 for HIP members and $502.48 for non-HIP beneficiaries.

Maryland

This experiment is jointly funded by SSA, Maryland Blue Cross, and the State of Maryland and is being conducted by Hospital Cost Analysis Service (HCAS) in 37 Maryland hospitals under a subcontract. HCAS reviews the costs of all participating hospitals on a department-by-department basis and those departments which are identified as high cost are studied in depth. As a result of the studies, recommendations are made to the hospitals indicating actions which can be taken to reduce costs.

Over 50 studies have been conducted by HCAS in participating Maryland hospitals. The hospitals are reported to have made acceptable progress in implementing the HCAS recommendations. HCAS estimates that $2,400,000 will be saved by the hospitals over a 2-year period, once all their suggestions are put into effect.

Birmingham

In January 1972, the Commissioner of Social Security approved the Birmingham Regional Hospital Council proposal for implementation as an incentive reimbursement experiment.

The first experimental year ended June 1973 but the results--earning a group incentive--are not yet available. During the first experimental year, the BRHC directed its cost containment efforts toward establishing group purchasing for commonly used supplies and pharamceuticals, promoting improved management techniques within the member hospitals and identifying high cost departments within the member hospitals.

Utah Cost Improvement Project

The Utah State Division of Health Cost improvement project for nonmetropolitan hospitals became effective January 1, 1973. The Utah proposal provides for the testing of a system of reimbursing costs of small, low occupancy rural hospitals that would make it economically feasible for such facilities to use their empty beds for varying levels of long-term care. Under the proposal, beds used for long-term care in a facility would be allocated a smaller share of the hospital's overhead costs than is presently required by Medicare reimbursement regulations. It appears that most of the facilities participating in the experiment would be able to add long-term patients without an increase in staff, so that the additional cost to a facility for providing such care appears likely to be small. By allocating a set amount to long-term beds that is somewhat more than the additional cost incurred by providing long-term care, acute hospitals costs in a facility would be lowered. Such a use of empty hospital beds for long-term care, besides saving the Medicare program money, should help the participating facilities financially, reduce the need for construction of new patient care beds in the community, allow the patient to remain in his home area, and provide more efficient care by retaining the patient under the same physician.

Durable Medical Equipment Experiments

This new class of experiments called for under Section 245 of the Social Security Amendments of 1972 is designed to eliminate unreasonable expenses resulting from prolonged rentals of Durable Medical Equipment (DME).[4/] Among possible approaches to DME experimentation are: Lump-sum payment, lease-purchase arrangements, and waiver of the coinsurance under certain conditions.

4/ Contracts for development of a protocol for experimentation with alternative forms of reimbursing for Durable Medical Equipment were awarded (through the REP process) in June 1974 to: Blue Shield of Maryland, Inc., Towson, Maryland; Conva-Care Services, Inc., Bedford, Indiana; and Exotech Systems, Inc., Gaithersburg, Maryland. The developmental phase is to be completed by September 1974 with the option open for experimentation at that time.

PART IX - PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Section 249F of Public Law 92-603 authorized, effective on and after January 1, 1974, the creation of a nationwide network of local medical peer review organizations called Professional Standards Review Organizations (PSRO's). These organizations are intended to help "promote the effective, efficient, and economical delivery of health care services of proper quality," where reimbursement for such services is made under the Social Security Act. Various means of achieving this end, including the establishment of norms of care, the use of precertification programs, retroactive reviews, and the continuing review of inpatient hospital cases, were included in the provision. The guiding philosophy behind the provision is that the review of services provided by physicians could only be accomplished adequately by physicians themselves. When a PSRO is operating effectively, the Secretary may waive other Medicare utilization review requirements.

Although the Social Security Administration is participating in PSRO program development, the Secretary has created two new components to provide policy and operational guidance for this new program. Overall policy guidance will be provided by the Office of Professional Standards Review, which is located directly under the Assistant Secretary for Health. Operational aspects of the program will be overseen by the Bureau of Quality Assurance, which is a component of the Health Services Administration. Both of these organizations reflect the new emphasis which has been placed on the Health arm of the Department as a source of health care policy and program leadership.

During the past year a great deal of staff work has been devoted to the designation of PSRO areas. These areas, which were published as proposed rule-making in the Federal Register in December 1973, will outline the geographic boundaries for each review organization. It is expected that agreements can be entered into with qualified organizations within a reasonable time after they apply. SSA is also monitoring several PSRO demonstration projects, anticipating that they will present valuable insights into operating review organizations.

Section 299I of Public Law 92-603 makes full Medicare coverage (hospital and medical insurance) available to people, under age 65, suffering from chronic renal disease (CRD) severe enough to require a regular course of dialysis or a kidney transplant. Entitlement begins the third month after the month in which a course of dialysis began or in the month in which the patient is hospitalized in anticipation of transplant surgery, provided that such surgery occurs in that month or in the following month. In addition to meeting the basic medical requirements, the individual must also be either currently or fully insured, or be entitled to monthly social security benefits, or be the spouse or dependent child of someone meeting these insured status requirements or qualifying for monthly benefits. Reimbursement is effective for covered services furnished on and after July 1, 1973.

Interim guidelines concerning the program were developed with extensive cooperation and assistance from professionals involved with and knowledgeable about the practices of nephrology and transplant surgery. They represent an effort to establish, with the guidance of professional medical advice, a program which would support high quality care for end-stage renal disease patients while being responsive to the need for appropriate cost containment. Professional guidance came from such groups as the National Kidney Foundation, Physicians for Renal Replacement Therapy, The Council on Medical Services of the American Medical Association, The American Society of Internal Medicine, and The National Association of Patients on Hemodialysis and Transplantation.1/

As a consequence of the short time period between enactment of the law and the date of implementation, the many complex issues raised could not be fully resolved before the first payments were to be made, so that some of the required operations were begun on the basis of interim regulations. The interim regulations, however, contained a general description of the direction that the long term regulations were expected to take. A major intent was to prevent further proliferation of unneeded facilities. It was expected that the interim regulations would permit orderly activation of the new program but would need to be revised periodically to reflect developing long-term policy as well as experience gained from the early months of operation.

1/ Final policies under which Medicare will pay for the care of patients with chronic renal disease were announced by DHEW in April 1974. Regulations will be developed to govern the establishment of regional treatment networks for delivering comprehensive high quality services with appropriate controls to assure reasonable costs to persons receiving renal treatment services under the program. In order to assure high quality care, local medical review boards will be established to monitor appropriateness of treatment and proper utilization of available facilities.

Entitlement

It is anticipated that approximately 14,000 to 15,000 people will become entitled during the first year and in each succeeding year thereafter, with a leveling off at a peak estimated to be about 45,000 to 50,000 beneficiaries by the end of the decade.2/

Facility Participation

In order to prevent a proliferation of unneeded facilities, a "freeze" was established which limited reimbursement--with provisions for exceptions--to only those facilities rendering CRD services prior to June 1, 1973. The exceptions procedure was adopted in order to accommodate unmet need for services. As of December 1973 there were approximately 600 facilities which were being reimbursed by the program for dialysis and/or transplantation services.

The Bureau of Quality Assurance of the Health Services Administration had the lead role in developing the necessary criteria to process facility qualification exceptions requests. These criteria have been formulated and forwarded to the Bureau of Health Insurance Regional Offices, which have released them to the 98 facilities that as of December 1973 had expressed a desire to either participate or substantially expand their current operations. The process includes review and adjudication of exceptions requests by a panel consisting of Bureau of Quality Assurance and Bureau of Health Insurance staff with outside renal experts called upon for their advice where the circumstances require such professional consultation. Input on community need is solicited from local and State comprehensive health planning agencies as part of the application process.

Long term regulations on conditions for coverage of services are intended to give support to the establishment of a rational delivery system which will assure each patient accessibility to all modalities of CRD therapy and which will operate at a high level of effectiveness. Preparation of these regulations is underway and will reflect careful consideration of the comments made by interested parties during the current interim period.

2/ As of July 19, 1974, a total of 17,958 applications for entitlement had been filed: 1,492 are still being processed, 2,164 have been denied, 14,302 have been approved. There are an additional 6,311 entitled beneficiaries, whose entitlement is based on the old age, survivors and disability insurance provisions of the law.

Reimbursement

The fact that virtually all renal dialysis and transplant services will be paid for under P.L. 92-603 makes it necessary to modify policies that were appropriate when only the aged were involved. The legislative history recognizes, for example, that this greatly expanded coverage removes the constraints on costs and charges that have been exercised in the past by the non-Medicare population and that new reimbursement guidelines will be necessary.

In the interim, facilities are required to have separate cost centers for their dialysis units and to complete supplemental billing forms designed to capture data not ordinarily available on traditional billing forms. In recognition of the wide variation of charges (or costs) for substantially the same service, facility billings are measured against screening amounts which represent an estimate of the reasonable cost for such services. Provision has been made whereby a facility demonstrating unusual circumstances can request a rate of reimbursement in excess of those screens. To ascertain whether or not a facility is justified in exceeding the screen, and to aid in determining an appropriate long-term reimbursement policy, cost questionnaires have been developed for completion by all dialysis facilities. In addition, with respect to reimbursement for physicians' services, present payment methods are being reviewed and optional alternative methods are being considered in view of the many unique features of delivery of care for CRD. 3/

Summary

As with any new program, one of the biggest problems has been to provide the basic information required to effectively begin operations and assure continuity of benefits. An initial delay in payments, due mainly to the time normally required to establish Medicare entitlement, has been substantially overcome. Of equal significance were the problems encountered by Medicare fiscal intermediaries in implementing new reimbursement and bill processing methods - in particular the problems of applying prepayment screens and combining a variety of services into one treatment charge. However, all current reports indicate most major claims processing and reimbursement problems are being satisfactorily resolved as they occur.

3/ A major element in the final policies announced in April 1974 is a new option for paying physicians for their services to patients with kidney disease. If physicians choose, they may elect to be paid a comprehensive monthly fee per patient for providing all necessary physician services to patients on dialysis. It is felt that this alternative to the normal method of reimbursement may aid in encouraging the use of less expensive home dialysis since the physician will be guaranteed a monthly payment for his renal patients and his reimbursement will not be on a strict fee for services basis.

APPENDIX A

SUMMARY DATA ON MEDICARE OPERATIONS

Summary Data On Medicare Operations

Beneficiaries

The number of persons entitled to hospital insurance increased to 21.4 million on January 1, 1973, a gain of 408,000 or 2.0 percent since January 1, 1972. The number of hospital insurance enrollees includes nearly every American age 65 and over. 1/

On January 1, 1973, the number of persons enrolled for supplementary medical insurance reached 20.5 million, representing a 399,000 or 2.0 percent increase since January 1, 1972. About 96 percent of the hospital insurance enrollees were also enrolled for medical insurance.

Health Care Resources

At the close of fiscal 1973, there was a net increase of 31 participating hospitals from the total at the end of fiscal 1972, bringing the number of hospitals participating in the Medicare program on June 30, 1973 to 6,757. Among participating hospitals there were 6,340 general hospitals, an increase of 40 from last year. The total number of beds in participating hospitals was 1,148,000, a decrease of 8,000.

By the end of fiscal 1973, there were 3,977 participating skilled nursing facilities (SNF's) with 287,606 beds--a decrease of 64 SNF's and 4,030 beds since a year earlier. A total of 2,211 home health agencies were certified to participate in Medicare on June 30, 1973, a decrease of 11 agencies during the year.

Since July 1, 1968, outpatient physical therapy services have been covered when furnished by, or under the supervision of, qualified "providers of service." In addition, physical therapy has been covered since the start of the program when furnished on an inpatient basis or in physicians' offices or as a part of covered home health services. At the end of fiscal year 1973, a total of 115 clinics, rehabilitation agencies and public health agencies--compared to 109 a year earlier--have been certified to participate as outpatient physical therapy providers, in addition to participating hospitals, skilled nursing facilities and home health agencies.

1/ Excluded from coverage were certain Federal employees covered under the Federal Employees Health Benefits Act, aliens admitted for permanent residence but not residing in the United States for 5 consecutive years preceding their application for hospital insurance entitlement, and persons convicted of crimes against the United States. Included in the total are beneficiaries residing in foreign countries and persons living in Puerto Rico and United States territories and possessions.

The following table summarizes the changes which have occurred in participating facilities between 1972 and 1973.

Type of facility	Facilities		
	July 1972	July 1973	Percent change
Hospitals 2/	6,726	6,757	+0.5
Short-stay	6,131	6,132	+.01
Psychiatric	346	352	+1.7
Tuberculosis	80	65	-18.8
Other long stay	169	208	+23.1
Skilled nursing facilities 2/	4,041	3,977	-1.6
Home health agencies	2,222	2,211	-0.5
Independent laboratories	2,873	2,929	+1.9

2/ Excludes 17 Christian Science sanatoriums.

Type of facility	Beds		
	July 1972	July 1973	Percent change
Hospitals 2/	1,155,982	1,148,428	-0.7
Short-stay	850,070	864,786	+1.7
Psychiatric	259,329	236,550	-8.8
Tuberculosis	15,065	13,048	-13.4
Other long stay	31,518	34,044	+8.0
Skilled nursing facilities 2/	291,636	287,606	-1.4

2/ Excludes 17 Christian Science sanatoriums.

Benefit Payments

In fiscal 1973, Medicare's seventh year, the program paid $6.7 billion in benefits under the hospital insurance program compared to $6.1 billion during fiscal 1972. Medical insurance benefit payments amounted to $2.4 billion, up from $2.3 billion paid in fiscal 1972.

An analysis of hospital insurance claims approved for payment in fiscal 1973 and recorded in SSA records shows that inpatient hospital services accounted for 89.2 percent of paid claims, but 97.1 percent of total disbursements. The respective percentage figures for other services were: extended care services, 4.4 percent of claims and 2.2 percent of disbursements; posthospital home health services, 6.5 of claims and 0.7 percent of disbursements.

A breakdown of medical insurance bills approved for payment in fiscal 1973 and recorded in SSA records indicates that physicians' services accounted for 80.4 percent of paid bills, and 87.7 percent of total disbursements. For other services, the respective percentage figures were: outpatient hospital services 11.6 percent of bills and 6.7 percent of disbursements; other medical services and supplies, 4.7 percent of bills and 4.0 percent of disbursements; home health care, 0.6 percent of bills and 0.8 percent of disbursements; and independent laboratory services, 2.6 percent of bills and 0.8 percent of disbursements. In fiscal 1973, excluding claims from hospital-based physicians, 53.4 percent of the claims submitted for physicians services were assigned. The total assignment percentage including hospital based physicians, was 57.5 percent.

Charges were reduced on 46.6 percent of approved claims processed by carriers in fiscal 1972 and on 52.9 percent of approved claims processed in fiscal 1973. The average dollar amount of reduction per reduced claim was $14.19 in fiscal 1973 and $15.30 in fiscal 1972. Total reduction on approved claims were $362 million in fiscal 1972 and $411 million in fiscal 1973.

Inpatient Hospital Services

During fiscal 1973, there were 6.8 million covered hospital admissions, up about 290,000 over fiscal 1972. The fiscal 1973 total represented an annual average of 320 admissions to short and long-term hospitals for every 1,000 persons covered under the program, a 2.2 percent increase over the previous year's rate of 313.

During fiscal 1973, a total of 2,082 claims for emergency hospital services were processed--a decrease of 1,300 claims from the preceding

year. About 59 percent were allowed, compared to 50 percent in fiscal 1972, while the remainder were either wholly or partially denied.

Hospitals were paid an estimated $6.4 billion for inpatient services during 1973, an increase of over $500 million over the preceding 12 months. Reimbursement averaged $877 per recorded inpatient hospital bill; the comparable figure for the previous year was $826.

Extended Care Services

During fiscal 1973, there were 405,400 admissions to skilled nursing facilities, up from 396,900 the previous year. The annual rate per 1,000 persons covered was 19.1 the same as in fiscal 1972. There was about one SNF for covered posthospital care, on the average, for every 17 hospital admissions.

An estimated $154 million was paid to SNF's during fiscal 1973. Reimbursement averaged $402 per recorded bill compared to $393 in fiscal 1972.

Home Health Services

During fiscal year 1973, an estimated $77 million was paid for home health services. This represented about a 12 percent increase from the previous year. The average payment per recorded bill was $92 under hospital insurance and $57 under medical insurance, compared to $89 and $54 respectively in the preceding 12-month period.

Outpatient Hospital Services

In fiscal 1973, 5.8 million outpatient hospital bills--both diagnostic and therapeutic--were reimbursed under Medicare, up from over 5.5 million during the previous 12 months. Total payments to hospitals for covered outpatient services were estimated at $222 million, up from $179 million in fiscal 1972.

Physicians' Services

In fiscal 1973, a total of 38.9 million bills for physicians' services were approved for payment and recorded in Social Security Administration records, in comparison to 39.3 million bills in fiscal 1972. Of these

bills, 15 percent were for surgical services and 85 percent for medical services. Reasonable charges for surgical bills amounted to $994 million compared to $990 million the previous year; for medical bills these charges amounted to $1.5 billion, the same as in the previous year.

For physicians' surgical services, the proportion of reasonable charges reimbursed by Medicare was 76.0 percent; for medical services, 72.2 percent.

Other Medical Services and Supplies

There were 3.5 million paid bills recorded for nonphysician medical services, other than home health and outpatient hospital services in fiscal 1973--up from 3.4 million in the preceding year.

Reasonable charges for independent laboratory services total $22 million compared to $20 million a year earlier, while the figure for "other medical services" was $111 million compared to $108 million a year earlier. Included in the "other" category, are rental or purchase of durable medical equipment, ambulance services, prosthetic devices, and certain other medical services and supplies.

APPENDIX B

SELECTED DATA FROM MEDICARE PROGRAM FOR FISCAL YEAR 1973

Selected Data from the Medicare Program for Fiscal Year 1973

	All Areas	Alabama	Alaska
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	21,374,693	347,172	7,337
Supplementary medical insurance (SMI)	20,544,688	340,138	5,917
Benefits paid (in thousands):			
Hospital insurance	6,749,000	91,793	1,843
Supplementary medical insurance	2,439,500	31,512	604
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	6,757	132	22
General hospitals	6,340	129	21
Number of beds	898,830	15,532	751
Number of beds per 1,000 HI enrollees	42.1	44.7	102.4
Psychiatric hospitals	352	1	1
Tuberculosis hospitals	65	2	-
Skilled nursing facilities	3,977	92	4
Number of beds 3/	287,606	5,320	147
Number of beds per 1,000 HI enrollees	13.5	15.3	20.0
Home health agencies	2,211	67	1
Independent laboratories	2,929	15	2
Number of admissions during the fiscal year 4/:			
All inpatient hospital	6,781,400	122,500	2,100
Skilled nursing facility	405,400	6,000	100
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	320	353	287
Skilled nursing facility	19.1	17.2	9.5

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Arizona	Arkansas	California
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	183,971	252,382	1,886,021
Supplementary medical insurance (SMI)	177,431	246,049	1,850,653
Benefits paid (in thousands):			
Hospital insurance	64,493	53,124	698,851
Supplementary medical insurance	24,245	20,017	331,549
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	58	98	598
General hospitals	54	96	560
Number of beds	7,322	8,455	79,998
Number of beds per 1,000 HI enrollees	39.8	33.5	42.4
Psychiatric hospitals	3	2	36
Tuberculosis hospitals	1	-	2
Skilled nursing facilities	16	12	905
Number of beds 3/	1,135	615	75,933
Number of beds per 1,000 HI enrollees	6.2	2.4	40.3
Home health agencies	10	77	83
Independent laboratories	47	10	735
Number of admissions during the fiscal year 4/:			
All inpatient hospital	60,600	101,900	578,100
Skilled nursing facility	3,100	800	97,800
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	329	404	307
Skilled nursing facility	17.1	3.1	51.8

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Colorado	Connecticut	Delaware
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	198,519	301,618	47,709
Supplementary medical insurance (SMI)	194,238	296,266	46,338
Benefits paid (in thousands):			
Hospital insurance	71,314	113,410	15,205
Supplementary medical insurance	24,752	32,480	4,908
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	87	52	10
General hospitals	83	43	8
Number of beds	10,064	11,226	1,851
Number of beds per 1,000 HI enrollees	50.7	37.2	38.8
Psychiatric hospitals	4	9	1
Tuberculosis hospitals	-	-	1
Skilled nursing facilities	62	123	11
Number of beds 3/	3,758	11,075	608
Number of beds per 1,000 HI enrollees	18.9	36.7	12.7
Home health agencies	24	86	7
Independent laboratories	40	50	10
Number of admissions during the fiscal year 4/:			
All inpatient hospital	77,100	81,400	12,300
Skilled nursing facility	4,000	11,400	700
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	388	270	258
Skilled nursing facility	20.1	37.8	14.5

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

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Selected Data from the Medicare Program for Fiscal Year 1973

	District of Columbia	Florida	Georgia
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	65,406	1,067,778	389,888
Supplementary medical insurance (SMI)	62,287	1,044,687	379,668
Benefits paid (in thousands):			
Hospital insurance	34,143	314,814	90,685
Supplementary medical insurance	13,144	148,538	35,045
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	16	202	172
General hospitals	13	189	162
Number of beds	5,400	32,499	19,106
Number of beds per 1,000 HI enrollees	82.6	30.4	49.0
Psychiatric hospitals	3	11	9
Tuberculosis hospitals	-	2	1
Skilled nursing facilities	5	149	68
Number of beds 3/	878	8,887	4,278
Number of beds per 1,000 HI enrollees	13.4	8.3	11.0
Home health agencies	5	36	15
Independent laboratories	4	135	27
Number of admissions during the fiscal year 4/:			
All inpatient hospital	22,100	344,800	133,000
Skilled nursing facility	500	20,600	4,500
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	338	323	341
Skilled nursing facility	7.5	19.2	11.5

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

	Hawaii	Idaho	Illinois
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	49,918	74,278	1,116,108
Supplementary medical insurance (SMI)	48,954	72,085	1,085,631
Benefits paid (in thousands):			
Hospital insurance	13,698	18,237	417,345
Supplementary medical insurance	8,709	6,157	114,256
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	25	47	286
General hospitals	24	47	265
Number of beds	2,738	2,685	50,221
Number of beds per 1,000 HI enrollees	54.8	36.1	45.0
Psychiatric hospitals	1	-	17
Tuberculosis hospitals	-	-	4
Skilled nursing facilities	13	32	156
Number of beds 3/	1,333	1,514	7,634
Number of beds per 1,000 HI enrollees	26.7	20.4	6.8
Home health agencies	5	9	83
Independent laboratories	17	2	176
Number of admissions during the fiscal year 4/:			
All inpatient hospital	14,200	25,000	358,200
Skilled nursing facility	1,100	1,600	14,800
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	285	337	321
Skilled nursing facility	22.2	21.3	13.3

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Indiana	Iowa	Kansas
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	511,865	359,570	276,681
Supplementary medical insurance (SMI)	494,499	351,821	269,373
Benefits paid (in thousands):			
Hospital insurance	136,045	94,317	75,334
Supplementary medical insurance	40,891	25,748	25,587
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	132	162	178
General hospitals	122	156	172
Number of beds	21,420	15,020	12,936
Number of beds per 1,000 HI enrollees	41.8	41.8	46.8
Psychiatric hospitals	8	5	5
Tuberculosis hospitals	2	1	1
Skilled nursing facilities	100	43	38
Number of beds 3/	4,246	1,353	1,119
Number of beds per 1,000 HI enrollees	8.3	3.8	4.0
Home health agencies	29	53	34
Independent laboratories	39	14	27
Number of admissions during the fiscal year 4/:			
All inpatient hospital	155,200	130,200	107,200
Skilled nursing facility	8,900	3,900	2,900
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	303	362	388
Skilled nursing facility	17.3	10.8	10.4

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Kentucky	Louisiana	Maine
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	351,678	322,187	124,751
Supplementary medical insurance (SMI)	345,004	296,085	122,532
Benefits paid (in thousands):			
Hospital insurance	77,266	86,802	32,590
Supplementary medical insurance	27,683	28,408	10,697
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	122	138	56
General hospitals	111	132	55
Number of beds	12,871	15,801	4,548
Number of beds per 1,000 HI enrollees	36.6	49.0	36.5
Psychiatric hospitals	5	5	1
Tuberculosis hospitals	6	1	-
Skilled nursing facilities	83	14	17
Number of beds 3/	5,117	1,240	666
Number of beds per 1,000 HI enrollees	14.6	3.8	5.3
Home health agencies	33	68	20
Independent laboratories	35	29	-
Number of admissions during the fiscal year 4/:			
All inpatient hospital	121,500	119,000	38,600
Skilled nursing facility	8,600	2,300	1,700
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	345	369	310
Skilled nursing facility	24.5	7.1	13.4

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Maryland	Massachusetts	Michigan
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	310,045	644,726	793,559
Supplementary medical insurance (SMI)	299,740	631,207	774,026
Benefits paid (in thousands):			
Hospital insurance	98,915	312,981	294,655
Supplementary medical insurance	34,053	72,010	89,987
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	61	182	248
General hospitals	52	161	234
Number of beds	12,682	30,014	36,484
Number of beds per 1,000 HI enrollees	40.9	46.6	46.0
Psychiatric hospitals	7	18	14
Tuberculosis hospitals	2	3	-
Skilled nursing facilities	59	89	146
Number of beds 3/	4,804	6,082	12,590
Number of beds per 1,000 HI enrollees	15.5	9.4	15.9
Home health agencies	22	163	47
Independent laboratories	63	108	94
Number of admissions during the fiscal year 4/:			
All inpatient hospital	74,600	200,800	240,600
Skilled nursing facility	5,200	11,100	12,900
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	241	311	303
Skilled nursing facility	16.8	17.2	16.3

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Montana	Nebraska	Nevada
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	72,186	188,316	37,075
Supplementary medical insurance (SMI)	70,279	183,429	35,654
Benefits paid (in thousands):			
Hospital insurance	17,574	48,233	15,997
Supplementary medical insurance	6,654	18,271	4,254
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	62	119	23
General hospitals	61	115	21
Number of beds	3,600	8,468	2,467
Number of beds per 1,000 HI enrollees	49.9	45.0	66.5
Psychiatric hospitals	1	4	2
Tuberculosis hospitals	-	-	-
Skilled nursing facilities	23	19	15
Number of beds 3/	711	911	506
Number of beds per 1,000 HI enrollees	9.8	4.8	13.6
Home health agencies	9	9	3
Independent laboratories	5	8	15
Number of admissions during the fiscal year 4/:			
All inpatient hospital	30,500	73,300	13,600
Skilled nursing facility	800	1,600	1,300
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	422	389	366
Skilled nursing facility	11.7	8.3	35.0

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Minnesota	Mississippi	Missouri
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	426,055	236,689	576,493
Supplementary medical insurance (SMI)	418,459	229,364	561,780
Benefits paid (in thousands):			
Hospital insurance	152,130	57,957	184,233
Supplementary medical insurance	43,950	32,387	55,613
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	194	111	171
General hospitals	185	110	162
Number of beds	20,050	9,586	25,320
Number of beds per 1,000 HI enrollees	47.1	40.5	43.9
Psychiatric hospitals	8	-	9
Tuberculosis hospitals	1	1	-
Skilled nursing facilities	84	21	57
Number of beds 3/	3,789	797	3,410
Number of beds per 1,000 HI enrollees	8.9	3.4	5.9
Home health agencies	62	85	28
Independent laboratories	14	13	60
Number of admissions during the fiscal year 4/:			
All inpatient hospital	164,300	94,100	209,100
Skilled nursing facility	7,500	1,100	6,100
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	386	398	363
Skilled nursing facility	17.6	4.7	10.5

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	New Hampshire	New Jersey	New Mexico
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	86,674	722,387	81,210
Supplementary medical insurance (SMI)	83,611	706,365	77,407
Benefits paid (in thousands):			
Hospital insurance	22,228	212,665	20,149
Supplementary medical insurance	7,627	94,069	7,468
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	32	127	47
General hospitals	30	116	45
Number of beds	3,220	28,251	3,734
Number of beds per 1,000 HI enrollees	37.2	39.1	46.0
Psychiatric hospitals	2	10	2
Tuberculosis hospitals	-	1	-
Skilled nursing facilities	16	116	10
Number of beds 3/	845	8,490	556
Number of beds per 1,000 HI enrollees	9.7	11.8	6.8
Home health agencies	39	45	6
Independent laboratories	2	133	23
Number of admissions during the fiscal year 4/:			
All inpatient hospital	26,900	182,500	26,300
Skilled nursing facility	2,400	16,000	900
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	310	253	323
Skilled nursing facility	27.8	22.2	10.7

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	New York	North Carolina	North Dakota
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	1,985,570	448,382	70,873
Supplementary medical insurance (SMI)	1,918,856	435,303	69,158
Benefits paid (in thousands):			
Hospital insurance	815,934	103,970	22,088
Supplementary medical insurance	313,787	32,846	6,256
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	402	151	57
General hospitals	363	142	56
Number of beds	83,147	19,854	3,497
Number of beds per 1,000 HI enrollees	41.9	44.3	49.3
Psychiatric hospitals	35	5	1
Tuberculosis hospitals	4	4	-
Skilled nursing facilities	325	55	5
Number of beds 3/	41,967	4,517	151
Number of beds per 1,000 HI enrollees	21.1	10.1	2.1
Home health agencies	127	46	9
Independent laboratories	230	12	9
Number of admissions during the fiscal year 4/:			
All inpatient hospital	520,400	141,600	32,400
Skilled nursing facility	39,200	6,700	400
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	262	316	457
Skilled nursing facility	19.7	15.0	6.1

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Ohio	Oklahoma	Oregon
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	1,024,457	311,785	241,404
Supplementary medical insurance (SMI)	991,661	305,576	231,266
Benefits paid (in thousands):			
Hospital insurance	313,727	80,347	63,830
Supplementary medical insurance	93,741	31,558	27,012
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	237	134	89
General hospitals	218	128	84
Number of beds	46,207	11,636	8,093
Number of beds per 1,000 HI enrollees	45.1	37.3	33.5
Psychiatric hospitals	12	5	4
Tuberculosis hospitals	7	1	1
Skilled nursing facilities	184	9	57
Number of beds 3/	14,154	507	2,633
Number of beds per 1,000 HI enrollees	13.8	1.6	10.9
Home health agencies	99	53	25
Independent laboratories	103	46	37
Number of admissions during the fiscal year 4/:			
All inpatient hospital	305,700	117,700	75,500
Skilled nursing facility	22,400	1,700	6,300
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	298	378	313
Skilled nursing facility	21.9	5.4	26.2

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Pennsylvania	Rhode Island	South Carolina
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	1,314,056	108,097	208,506
Supplementary medical insurance (SMI)	1,269,492	105,389	198,513
Benefits paid (in thousands):			
Hospital insurance	412,095	40,716	42,988
Supplementary medical insurance	148,054	13,615	13,251
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	284	18	79
General hospitals	252	16	74
Number of beds	49,837	4,821	9,792
Number of beds per 1,000 HI enrollees	37.9	44.6	47.0
Psychiatric hospitals	30	2	4
Tuberculosis hospitals	2	-	1
Skilled nursing facilities	217	20	67
Number of beds 3/	16,569	1,098	4,412
Number of beds per 1,000 HI enrollees	12.6	10.2	21.2
Home health agencies	110	13	26
Independent laboratories	129	20	11
Number of admissions during the fiscal year 4/:			
All inpatient hospital	374,100	29,200	62,500
Skilled nursing facility	22,700	2,900	4,400
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	285	271	300
Skilled nursing facility	17.2	27.0	21.2

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	South Dakota	Tennessee	Texas
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	83,263	408,706	1,057,119
Supplementary medical insurance (SMI)	80,757	398,399	1,038,919
Benefits paid (in thousands):			
Hospital insurance	22,127	111,683	316,264
Supplementary medical insurance	6,136	32,064	130,280
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	62	149	493
General hospitals	62	141	475
Number of beds	3,580	19,470	49,021
Number of beds per 1,000 HI enrollees	43.0	47.6	46.4
Psychiatric hospitals	-	4	15
Tuberculosis hospitals	-	4	3
Skilled nursing facilities	8	54	61
Number of beds 3/	271	2,199	3,617
Number of beds per 1,000 HI enrollees	3.3	5.4	3.4
Home health agencies	21	84	44
Independent laboratories	4	23	149
Number of admissions during the fiscal year 4/:			
All inpatient hospital	34,500	151,600	425,400
Skilled nursing facility	600	6,100	4,900
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	414	371	402
Skilled nursing facility	7.6	14.8	4.7

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Utah	Vermont	Virginia
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	83,494	51,548	388,669
Supplementary medical insurance (SMI)	79,848	50,493	372,519
Benefits paid (in thousands):			
Hospital insurance	19,626	17,414	93,054
Supplementary medical insurance	8,685	5,026	40,903
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	38	19	118
General hospitals	37	17	107
Number of beds	3,466	1,880	19,215
Number of beds per 1,000 HI enrollees	41.5	36.5	49.4
Psychiatric hospitals	1	2	10
Tuberculosis hospitals	-	-	1
Skilled nursing facilities	18	21	41
Number of beds 3/	600	1,238	1,779
Number of beds per 1,000 HI enrollees	7.2	24.0	4.6
Home health agencies	9	17	136
Independent laboratories	15	5	27
Number of admissions during the fiscal year 4/:			
All inpatient hospital	24,300	17,900	120,700
Skilled nursing facility	1,200	2,400	3,400
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	291	347	311
Skilled nursing facility	14.4	46.3	8.7

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

	Washington	West Virginia	Wisconsin
Number of beneficiaries as of January 1, 1973 1/:			
Hospital insurance (HI)	341,307	205,003	494,751
Supplementary medical insurance (SMI)	332,584	199,549	484,503
Benefits paid (in thousands):			
Hospital insurance	95,354	47,498	163,335
Supplementary medical insurance	36,218	21,999	44,748
Number of participating facilities as of July 1, 1973:			
All hospitals 2/	114	78	169
General hospitals	108	76	156
Number of beds	11,637	9,068	21,108
Number of beds per 1,000 HI enrollees	34.1	44.2	42.7
Psychiatric hospitals	5	2	9
Tuberculosis hospitals	1	-	4
Skilled nursing facilities	98	24	107
Number of beds 3/	3,708	1,481	5,615
Number of beds per 1,000 HI enrollees	10.9	7.2	11.3
Home health agencies	23	18	68
Independent laboratories	67	11	19
Number of admissions during the fiscal year 4/:			
All inpatient hospital	111,200	76,900	161,700
Skilled nursing facility	9,100	1,600	6,200
Number of admissions per 1,000 HI enrollees:			
All inpatient hospital	326	375	327
Skilled nursing facility	26.6	7.9	12.5

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Wyoming	Puerto Rico
Number of beneficiaries as of January 1, 1973 1/:		
Hospital insurance (HI)	32,413	193,666
Supplementary medical insurance (SMI)	31,215	100,688
Benefits paid (in thousands):		
Hospital insurance	7,647	19,894
Supplementary medical insurance	2,462	9,525
Number of participating facilities as of July 1, 1973:		
All hospitals 2/	29	62
General hospitals	28	61
Number of beds	1,532	7,029
Number of beds per 1,000 HI enrollees	47.3	36.3
Psychiatric hospitals	1	1
Tuberculosis hospitals	-	-
Skilled nursing facilities	1	6
Number of beds 3/	21	689
Number of beds per 1,000 HI enrollees	0.6	3.6
Home health agencies	10	8
Independent laboratories	3	57
Number of admissions during the fiscal year 4/:		
All inpatient hospital	12,200	43,200
Skilled nursing facility	200	900
Number of admissions per 1,000 HI enrollees:		
All inpatient hospital	376	223
Skilled nursing facility	5.8	4.8

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

Selected Data from the Medicare Program for Fiscal Year 1973

	Guam, Virgin Islands and Other Outlying Areas
Number of beneficiaries as of January 1, 1973 1/:	
Hospital insurance (HI)	5,173
Supplementary medical insurance (SMI)	4,204
Benefits paid (in thousands):	
Hospital insurance	383
Supplementary medical insurance	61
Number of participating facilities as of July 1, 1973:	
All hospitals 2/	5
General hospitals	5
Number of beds	620
Number of beds per 1,000 HI enrollees	119.9
Psychiatric hospitals	-
Tuberculosis hospitals	-
Skilled nursing facilities	1
Number of beds 3/	33
Number of beds per 1,000 HI enrollees	6.4
Home health agencies	2
Independent laboratories	-
Number of admissions during the fiscal year 4/:	
All inpatient hospital	1,100
Skilled nursing facility	5/
Number of admissions per 1,000 HI enrollees:	
All inpatient hospital	207
Skilled nursing facility	1.5

1/ Based on data recorded as of October 1, 1973.

2/ Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

3/ Includes skilled nursing beds only.

4/ Data reported reflect the actual date of admission notices received and processed by the Social Security Administration through December 1973. The geographic distribution reflects the location of the facility providing services. Figures are subject to revision as additional admission notices in fiscal year 1973 are received and processed by the Social Security Administration.

5/ Less than 50 admissions.

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APPENDIX C

SOCIAL SECURITY AMENDMENTS OF 1972 (Public Law 92-603): SUMMARY OF MEDICARE PROVISIONS

SOCIAL SECURITY AMENDMENTS OF 1972 (Public Law 92-603):

SUMMARY OF MEDICARE PROVISIONS

Medicare for the disabled.--Medicare protection is extended to persons entitled for not less than 24 consecutive months to cash benefits under the social security and railroad retirement programs because they are disabled. Coverage includes disabled workers at any age, disabled widows, and disabled dependent widowers between ages 50 and 65; women aged 50 or older who are entitled to mother's benefits and, for 24 months before the first month they would have been entitled to Medicare protection, met all the requirements for disability benefits except for actual filing of a disability claim; adult disabled children (of deceased, disabled, or retired workers) aged 18 and over who receive social security benefits because they became disabled before reaching age 22; and disabled qualified railroad retirement annuitants.

Medicare protection under this provision will begin with the later of (a) July 1973 or (b) the 25th consecutive month of an individual's entitlement to social security disability benefits and will terminate the month following the month notice of termination of disability benefits is mailed. (Section 201)

Chronic kidney disease deemed to constitute a disability for purposes of Medicare.--Effective July 1, 1973, Medicare coverage is extended to individuals under age 65 who are currently or fully insured or entitled to monthly social security benefits, and to the spouses or dependent children of such individuals, who require hemodialysis or renal transplantation for chronic renal disease. Such individuals are deemed to be disabled for purposes of coverage under both parts of Medicare. Eligibility for coverage begins with the third month after the month in which a course of renal hemodialysis begins, unless the claimant received a kidney transplantation in or before such third month. In the latter event, coverage may begin with the month of transplantation or with prior month, if in such prior month and continuing until the transplant occurs, he is hospitalized in preparation for an anticipation of such transplant surgery. Coverage extends through the twelfth month after the month in which an individual had a transplant or dialysis termintes. Benefits include those of both parts of Medicare, with the usual deductibles and coinsurance. The Secretary is authorized to limit reimbursement for treatment to kidney disease treatment centers that meet regulatory requirements. These requirements include a minimal utilization rate for covered procedures and a medical review board to screen the appropriateness of patients for the proposed treatment procedures. (Section 299I)

Health Maintenance Organization option.--Individuals eligible for both parts of Medicare, or for SMI only, may choose to have their covered health care provided through a health maintenance organization (HMO)--a prepaid group health or other capitation plan that meets prescribed standards. Two methods of reimbursement for HMO's are to be established. Under the first, an HMO will be "at risk" and payments will be made on an incentive capitation basis. This method, which can be used only by substantial, established HMO's will permit the HMO and the Government to share, according to a prescribed formula, in any savings the HMO achieves in relation to adjusted average per capita costs of covered health services for persons outside the HMO. The second method, which must be used by newly established HMO's and may be used by any other HMO, provides for interim monthly capitation payments subject to year-end adjustment that reflects the HMO's actual reasonable costs of providing Medicare-covered services.

A beneficiary enrolled with an establihsed HMO that uses the risk-sharing method of reimbursement will receive covered services only through the HMO, except for emergency services and urgently needed services received when he is temporarily outside the HMO's service area. A beneficiary enrolled in an HMO receiving cost reimbursement will not be required to use the HMO as his single source of health care. Payment will be made by Medicare in the usual manner for services he receives outside the HMO.

The provision is effective with respect to services provided on or after July 1, 1973. (Section 226)

Professional Standards Review Organizations.--By January 1, 1974, the Secretary must establish areas throughout the United States with respect to which Professional Standards Review Organizations (PSRO's) may be designated. They are to consist of substantial numbers of practicing physicians (usually 300 or more) in a local area and will be responsible for comprehensive and ongoing review of services covered under the Medicare, Medicaid, and maternal and child health care programs. They are to assure that services are (1) medically necessary and (2) provided in accordance with professional standards. The PSRO's are not required to review services other than institutional care and services unless they so choose and the Secretary agrees. They will not be involved with reasonable charge determinations; they are required to recognize and use utilization review committees in hospitals and other medical organizations to the extent these are deemed effective by the PSRO. Safeguards, designed to protect the public interest and to prevent pro forma carrying out of review responsibilities, include appeals procedures.

Until January 1, 1976, the Secretary will be able to make an agreement only with a qualified organization representing a substantial proportion of the physicians in the designated geographical area. Until January 1, 1976, the Secretary is also required to poll the practicing physicians in the area--at the request of 10 percent or more of such physicians--to determine whether or not an organization of physicians that has requested an agreement with the Secretary to establish a PSRO substantially represents the area's practicing physicians. If more than 50 percent of the practicing physicians responding to the poll indicate that the organization does not substantially represent them, the Secretary cannot enter into an agreement with that organization. (Section 249F)

Level-of-care requirements in skilled nursing facilities.--The Medicare definition of covered extended-care services is broadened somewhat, and the same definition applies to skilled nursing facility services under Medicaid. Services covered are those provided directly by or requiring the supervision of skilled nursing personnel, or skilled rehabilitation services needed by the patient on a daily basis that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. Medicare coverage will also continue during short periods when no skilled services were actually provided but when discharge from a skilled facility for such brief period is neither desirable nor practical. This provision is applicable to services furnished after December 31, 1972. (Section 247)

Waiver of beneficiary liability in certain situations where Medicare claims are disallowed.--Medicare beneficiaries who were without fault will be relieved of liability for disallowed services where the disallowance is based on determinations that the services were not medically necessary or did not meet level-of-care requirements. Where the beneficiary is "held harmless," liability shifts either to Medicare or, where it is found that the provider has not acted with due care, to the provider. This provision is applicable to claims for services provided after October 30, 1972. (Section 213)

Advance approval of extended care and home health coverage.--The Secretary is authorized to establish, by medical condition, specified periods of time after hospitalization during which a patient will be presumed to require an extended care level of services. Where a patient's physician certifies to the need for such care and submits to the skilled nursing facility, in advance of admission, a plan for carrying out the services, the care furnished will be assumed to be the type of care covered as extended care. Comparable provisions applying to posthospital home health services are also included. The advance approval provisions can, however, be declared inapplicable to patients of any physician who is found to be unreliable in certifying patients' need for such care. This provision is

effective for admissions for extended care services or the initiation of home health plans on or after January 1, 1973. (Section 228)

Hospital insurance for the uninsured.--Persons reaching age 65 who are ineligible for hospital insurance may enroll, on a voluntary basis, for such coverage under the same conditions as for supplementary medical insurance. Those who enroll will pay the full cost of the protection--$33 a month at the beginning and more in later years as hospital costs rise; enrollment for supplementary medical insurance is also required. States and public organizations, through agreements with the Secretary, may pay the premium for their aged retired (or active) employees. Coverage under this provision will be effective on July 1, 1973. (Section 202)

Medicare services outside the United States.--Inpatient hospital services furnished a resident of the United States in a foreign hospital that is closer or substantially more accessible to his residence than the nearest suitable United States hospital will be covered whether or not an emergency exists. Payments under SMI for necessary physicians and ambulance services furnished in connection with such hospitalization are also authorized. Medicare payments are also authorized for emergency inpatient hospital services and related physician and ambulance services needed by beneficiaries traveling in Canada between Alaska and another State. This provision applies to hospital admissions after December 31, 1972. (Section 211)

Elimination of provisions preventing enrollment under SMI more than 3 years after first opportunity.--Eligible persons may enroll under SMI during any prescribed enrollment period. Beneficiaries are no longer required to enroll within 3 years following first eligibility or a previous withdrawal from the program. The requirement that the SMI premium for late enrollees be increased 10 percent for each 12 months elapsing between the time they could have enrolled and actually do enroll is retained.

This provision is effective October 30, 1972. It applies to all those ineligible to enroll because of the 3-year limit in effect under the old law. (Section 260)

Coordination between Medicare and Federal employees' plans.--Effective January 1, 1975, no payment will be made under Medicare for the same services covered under a Federal employees health benefits (FEHB) plan unless in the meantime the Secretary certifies that such plan or the FEHB program has been modified to make available

to Federal employees and retirees coverage supplementary to Medicare benefits and a contribution toward their health insurance premiums in an amount equal to the Government's contribution toward high option coverage. (Section 210)

Uniform Medicare and Medicaid standards for nursing facilities.--A single "skilled nursing facility" definition is established, as well as a single set of health, safety, environmental, and staffing standards for institutions formerly identified as extended care facilities under Medicare and skilled nursing homes under Medicaid. In the future, extended care services covered under Medicare will be provided in institutions identified as "skilled nursing facilities." Under both Medicare and Medicaid, a "skilled nursing facility" must meet the existing statutory conditions of participation for extended care facilities plus certain additional requirements that skilled nursing homes must meet under existing Medicaid law. Where a skilled nursing facility desires to participate under both Medicare and Medicaid, the Secretary's determination that it meets Medicare standards would also serve for Medicaid. Uniformity of standards was effective as of July 1, 1973. (Section 246)

Reimbursement rates for skilled nursing facilities and intermediate care facilities.--States will be required to develop methods for reimbursing skilled nursing facilities and intermediate-care facilities on a basis reasonably related to cost and to implement these methods under Medicaid (after approval by the Secretary) by July 1, 1976. These State payment rates for skilled nursing facilities can then be used under Medicare in reimbursing for extended care services. The Medicaid rates can be adjusted upward, but not more than 10 percent, to account for specific factors related to Medicare not included by the State in computing Medicaid rates. (Section 249)

14-day-transfer requirement for posthospital extended care benefits.--The Medicare extended care benefit requirement that a patient's transfer to a skilled nursing facility take place within 14 days of his discharge from a hospital is modified to permit a longer interval for patients whose conditions do not permit provision of skilled services within 14 days (for example, a patient whose hip fracture has not mended to the point that physical therapy and restorative nursing can be utilized). An extension, not to exceed 2 weeks beyond the original 14 days, is authorized also in instances where admission to a facility providing extended care services is prevented because of a shortage of appropriate bed space in a geographic area. (Section 248)

Medical social services.--The Secretary may no longer require the provision of medical social services as a condition of participation for skilled nursing facilities under Medicare and Medicaid. (Section 265)

Waiver of registered nurse requirement in skilled nursing facilities in rural areas.--The Secretary may waive the requirement that a skilled nursing facility must employ a registered nurse full time (to the extent that "full time" is deemed to mean more than 40 hours a week) for certain rural skilled nursing facilities unable to assure the presence of a full-time registered nurse 7 days a week. A facility of this type that has one full-time registered nurse will be allowed a special waiver of the nursing requirement with respect to not more than two day shifts--over a weekend, for example. This special waiver will be authorized if the facility has only patients whose physicians have indicated that the individual can be without a registered nurse's services for a 48-hour period. If the facility has any patients for whom physicians have indicated a need for daily skilled nursing services, it must make arrangements for a registered nurse or a physician to spend enough time at the facility to provide the skilled services needed. (Section 267)

Amount of supplementary medical insurance premium.--The Secretary will continue to determine and promulgate in December 1972 and each year thereafter a monthly enrollee premium (applicable for both the aged and the disabled) for the following fiscal year. The enrollee premium will, however, be increased only in the event of a general benefit increase--either an automatic increase or one resulting from future legislation. In any given year, the premium will rise by no more than the percentage by which cash benefits have been increased across the board since the premium was last increased. Federal general revenues will finance that part of program costs not met through enrollee premiums.

The change is effective for the fiscal year beginning July 1973. (Through June 1973, the premium amount was $5.80.) (Section 203)

Change in SMI deductible.--The SMI deductible is increased from $50 to $60 as of January 1, 1973. (Section 204)

Elimination of coinsurance payment with respect to home health services under SMI.--Payments for home health services furnished under SMI are to be in amounts equal to 100 percent of the reasonable cost of services, rather than 80 percent as in the old law. (Section 299K)

Automatic enrollment for SMI.--Aged and disabled beneficiaries, except for residents of Puerto Rico and foreign countries, will be automatically enrolled for SMI as they become entitled to hospital insurance. Persons eligible for automatic enrollment will, to the extent possible, be fully informed and given an opportunity to decline the coverage. This provision applies to any such individual whose initial enrollment period begins after March 31, 1973. (Section 206)

Coverage of chiropractors' services under SMI.--Coverage is provided for the services of licensed chiropractors who also meet uniform minimum standards, but only with respect to treatment by means of manual manipulation of the spine and only with respect to treatment for a subluxation of the spine demonstrated by X-ray. This provision became effective July 1, 1973. (Section 273)

Limitation on Federal participation for capital expenditures.--The Secretary may withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, or other expenses related to capital expenditures for plant and equipment in excess of $100,000, or which change the bed capacity, which substantially change the facilities' services, or which are determined to be inconsistent with State or local health facility plans. The Secretary will act on the basis of findings and recommendations submitted to him by various health facility planning agencies. If, after consultation with an appropriate national advisory council, the Secretary determines that a disallowance of expenses will discourage the operation or expansion of an organization that has demonstrated capability of economically providing comprehensive health care services or will otherwise be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he is authorized to allow such expenses. This provision is effective with respect to obligations for capital expenditures incurred after December 31, 1972, or earlier, if a State so requests. (Section 221)

Experiments and demonstration projects in prospective reimbursement and incentives for economy.--The Secretary is authorized to test various methods of making payment to providers of services on a prospective basis under the Medicare, Medicaid, and maternal and child health programs. In addition, he is authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy (including payment for services furnished by organizations providing comprehensive, mental, or ambulatory health care services, as well as ambulatory surgical centers); with performance incentives for intermediaries and carriers; with reimbursement implications of paying for services rendered by physicians' assistants; with the use of intermediate care and homemaker services by beneficiaries who either are ready for discharge from a hospital or are unable to maintain themselves at home without assistance; and with programs designed to improve the rehabilitation of patients in long-term health care facilities. The Secretary is also authorized to determine whether services of clinical psychologists might be made more generally available to persons eligible under Medicare and Medicaid. (Section 222)

Limitations on recognition of increase in prevailing charge levels for medical and other health services.--To determine the reasonableness of charges by physicians under Medicare, Medicaid, and maternal and child health programs: (a) after December 31, 1970, medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the calendar year elapsing before the start of the fiscal year; (b) for fiscal year 1974 and thereafter, the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another. Charges allowed as reasonable after December 1972 may not exceed the lowest levels at which such supplies, equipment, and services are widely and consistently available in a locality. (Section 224)

Consultants for skilled nursing facilities.--

State agencies that are able and willing to do so could, with the Secretary's approval, furnish consultative services to skilled nursing facilities to enable them to meet Medicare requirements for use of consultants in certain specialty areas. Medicare payment would be made directly to the State agency for the cost of providing these consultative services. (Section 277)

Physical therapy and other therapy services under Medicare.--Beginning July 1, 1973, the services of a physical therapist in independent practice are covered under the supplementary medical insurance program when furnished in the therapist's office or the patient's home. Reimbursement would be based on not more than $100 of incurred expenses in a calendar year.

Beginning January 1, 1973, a hospital or extended care facility may provide covered outpatient physical therapy services under the supplementary medical insurance program to its inpatients who have exhausted their days of hospital insurance coverage. In addition, payments to providers for the reasonable cost of physical therapy services furnished under arrangements with others will be limited to amounts equivalent to the salary and other costs that would have been payable if the services had been performed in an employment relationship, plus the cost of such expenses an individual not working as an employee might have, such as maintaining an office, travel expenses, and similar costs. (Section 251)

Coverage of speech pathology services under supplementary medical insurance program.--Outpatient speech pathology services furnished by approved providers of outpatient physical therapy are covered under the same requirements applicable to the coverage of outpatient physical therapy services, effective January 1, 1973. (Section 283)

Extension of grace period for termination of supplementary medical insurance coverage where failure to pay premiums is due to good cause.--The 90-day grace period is extended for an additional 90 days where the Secretary finds there is good cause for failure to pay the premium before the expiration of the initial 90-day grace period. This provision applies beginning with cases of nonpayment of premiums due within the 90-day period preceding October 30, 1972. (Section 257)

Extension of time for filing claim for supplementary medical insurance benefits where delay is due to administrative error.--Supplementary medical insurance benefits may be paid to the beneficiary when a claim is not filed timely due to an administrative error. This provision assures that claimants will not be treated inequitably because of such an error and applies to bills submitted and requests for payment made after March 1968. (Section 258)

Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction.--The Secretary is authorized to provide equitable relief in situations where an individual's enrollment or nonenrollment in Part B of Medicare is other than it should be because of administrative error, misrepresentation, or inaction on the part of an officer, employee, or agent of the Federal Government. (Section 259)

Requirement of minimum amount of claim to establish entitlement to hearing under supplementary medical insurance program.--Carriers are required to hold fair hearings in response to disagreements over amounts paid under supplementary medical insurance only when the amount in controversy is $100 or more.

This provision applies to hearings requested after October 30, 1972. (Section 262)

Collection of supplementary medical insurance premiums from individuals entitled to both social security and railroad retirement benefits.--The Railroad Retirement Board is made responsible for collecting supplementary medical insurance premiums for enrollees entitled under that program. The Railroad Retirement Board is authorized to contract with a carrier or carriers for purposes of servicing its beneficiaries with respect to Part B benefits. This provision applies to premiums becoming due and payable after February 1973. (Section 263)

Refund of excess premiums under Medicare.--Provision is made for the refund of hospital insurance or supplementary medical insurance premiums paid by or on behalf of a deceased individual for months after the month of death. Refund is to the person who paid the premiums, the legal representative of the estate, or other survivor, as appropriate. (Section 266)

Payment for prosthetic lenses under the supplementary medical insurance program.--Licensed optometrists are recognized as "physicians" under Medicare, but only for the purposes of attesting to a beneficiary's need for prosthetic lenses, thus permitting payment for such lenses ordered by an optometrist. This change does not provide for the coverage of services not covered under present law. (Section 264)

Coverage of supplies related to colostomies.--Effective October 30, 1972, colostomy bags and supplies directly related to colostomy care are covered as prosthetic devices under the supplementary medical insurance program. (Section 252)

Payment for supervisory physicians in teaching hospitals.--Teaching physicians in hospitals must be reimbursed on a cost basis for services to patients unless (1) the patient is a bona fide private patient, or (2) the hospital has customarily charged all patients, and collected from a majority of them, on a fee-for-service basis. Also, a hospital will be permitted to include among its reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as hospital services.

Reimbursement on a cost basis under part A is authorized for services furnished by an intern or resident in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

The amendment with respect to supervisory physicians' in teaching hospitals is effective for accounting periods beginning after June 30, 1973. The provision relating to the services of podiatric interns and residents is effective with respect to accounting periods beginning after December 31, 1972. (Sections 227 and 276)

Limits on costs recognized as reasonable.--The Secretary is authorized to limit provider costs to be recognized as reasonable under Medicare based on comparisons of the cost of covered services by various classes of providers in the same geographical area. For other than emergency care, hospitals and skilled nursing facilities could charge beneficiaries for the costs of services in excess of those found necessary to the efficient delivery of needed health services

(except in the case of an admission by a physician who has a financial interest in the facility). This provision is effective for accounting periods beginning after December 31, 1972. (Section 223)

Authority to terminate payments to suppliers of services.--The Secretary is authorized to terminate or suspend payments under the Medicare program for services rendered by any supplier of health and medical services found quilty of program abuses. The Secretary is required to make the names of such persons or organizations public so that beneficiaries will be informed of those which cannot participate in the program. The situations for which termination of payment will be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Also, there will be no Federal financial participation in any expenditure under the Medicaid and maternal and child health programs by the State with respect to services furnished by a supplier to whom the Secretary would not make Medicare payments under this provision of the bills Program review teams will be established to furnish professional advice to the Secretary in carrying out this authority. Any person or organization dissatisfied with the Secretary's decision to terminate payments will be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision. (Section 229)

Validation of surveys made by the Joint Commission of the Accreditation of Hospitals in Medicare.--The Secretary is authorized to enter into an agreement with any State under which the State certifying agency would survey hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) on a selective and limited basis, or would survey a specific hospital where the Secretary finds that a survey, or more limited investigation, is appropriate because he has received a substantial allegation, with evidence, of the existence of a condition significantly adverse to patient health or safety. These sample and special surveys will serve as a mechanism to validate the JCAH survey process. If, in the course of such a survey, an institution is found to have significant deficiencies, following timely discussion of such deficiencies with the JCAH, the detailed Medicare standards and compliance procedures will be applied in place of the general JCAH standards. The Secretary is authorized, after consultation with the JCAH, to promulgate standards, as necessary for health and safety, which may be higher or more precise than those of the JCAH and which all hospitals would have to meet after appropriate and adequate time for compliance. (Section 244)

Government payment no higher than charges.--Effective for accounting periods beginning after 1972, payment for institutional services under the Medicare, Medicaid, and maternal and child health programs may, generally, not be higher than the charges regularly made for these services. (Section 233)

Institutional planning.--Each provider of services is required, as a condition of participation under Medicare, to have a written plan reflecting an operating budget and a capital expenditures budget covering the immediate subsequent one and three accounting years. The plan, which will be reviewed and updated annually, is expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of $100,000 for acquisition or improvement of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and proposed methods of financing the costs. This provision is effective for a provider of services for any fiscal year beginning after March 1973. (Section 234)

Prohibition against reassignment of claims.--Payment under Medicare and Medicaid to anyone other than the patient, his physician, or other person who provided the service is prohibited unless the physician or other person is required as a condition of his employment to turn over his fees to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. Direct payment could, however, be made to a foundation or other organization which provides and administers health care through an organized health care delivery system. This provision is effective with respect to bills submitted after October 30, 1972 for Medicare, and January 1, 1973 for Medicaid (or earlier, if the State plan so provides). (Section 236)

Notification of unnecessary admission to a hospital or extended care facility.--The responsibility of hospital and skilled nursing facility utilization review committees is expanded to require notification in any case which, in the course of a review of a current sample of admissions, it is determined that admission to or further stay in the institution is not medically necessary. Payment would be terminated under the same procedures now applied to cases of extended duration where the committee determines that further stay is not medically necessary. (Section 238)

Hospital admissions for dental services.--A certification of medical necessity is required to be made where a patient must be hospitalized in connection with a dental procedure for management of other severe impairments. The dentist who is caring for a patient may make the determination that such hospitalization is necessary without corroborating certification by a physician. Hospital stays under this provision will be covered effective with admissions after December 1972. (Section 256)

Durable medical equipment.--The Secretary is authorized to experiment with reimbursement approaches designed to prevent unreasonable expenses to Medicare resulting from prolonged rentals (rather than purchase) of durable medical equipment and to implement without further legislation any purchase approach found to be workable, desirable, and economical. (Section 245)

Penalties for fraudulent acts and false reporting under Medicare and Medicaid.--Present penalty provisions relating to the making of a false statement or representation of a material fact in any application for Medicare or Medicaid payments are broadened to include the soliciting, offering, or acceptance of kickbacks or bribes by providers of health care services; concealment or failure to disclose an event affecting a person's right to benefits with intent to defraud; or converting benefit payments to improper use. The penalty for such acts is imprisonment up to one year, a fine of $10,000, or both. Similarly, anyone who knowingly and willfully makes a false statement of material fact with respect to the conditions and operation of a facility or agency to secure Medicare or Medicaid certification or recertification would be guilty of a misdemeanor punishable by up to 6 months' imprisonment, a fine of not more than $2,000, or both. (Section 242)

Proficiency testing for health personnel.--The Secretary (in conjunction with appropriate professional health organizations and State health and licensure agencies) is required to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present Medicare regulations. Such testing program is to be applied through December 31, 1977, after which persons entering the health care fields in question would need to meet the regular formal education, professional membership, or other requirements. (Section 241)

Provider Reimbursement Review Board.--A Provider Reimbursement Review Board is established to review disputes between an intermediary and a provider concerning the intermediary's final determination (or failure to make a timely final determination) on a properly filed cost report, where the amount in controversy is at least $10,000. Groups of providers could appeal to the Board on common issues where the amounts in controversy aggregate $50,000 or more. Decisions of the Board would be final unless the Secretary reverses the Board's decision within 60 days, in which case the provider would have the right to judicial review. The provision is effective with respect to cost reports for accounting periods ending on or after June 30, 1973. (Section 243)

Withholding of Federal Medicaid matching amounts for certain terminated Medicare providers.--The Secretary is authorized to withhold (subsequent to 60 days notice to a State) future Federal Medicaid payments with respect to institutions which have withdrawn from Medicare without refunding Medicare overpayments or submitting cost reports to account for Medicare payments to them during their participation in that program. (Section 290)

Authority of Secretary to administer oaths and affirmations in Medicare proceedings.--The Secretary, in carrying out his responsibility for administration of the Medicare program is authorized to administer oaths and affirmations in the course of any hearing, investigation, or other proceeding. (Section 289)

Appeals and judicial review under Medicare.--Previous law is clarified by a provision specifying that there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B and that insofar as the amount of benefits under Part A is involved, an appeal is authorized only if the amount in controversy is $100 or more and judicial review only if the amount in controversy is $1,000 or more. (Section 2990)

Disclosure of information concerning performance of carriers, intermediaries, State agencies, and providers of services.--The Secretary is required to make public the following types of evaluations and reports: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews: (2) comparative evaluations of the performance of contractors--including comparisons of either overall performance or of any particular contractor operations; (3) program validation survey reports--with the names of individuals deleted. Contractors or providers being evaluated will be given reasonable opportunity to review and comment on such reports; pertinent parts of their comments will be incorporated in the reports. This provision applies to reports which are completed by the Secretary after January 1973. (Section 249C)

Public Disclosure of surveys of providers.--The Secretary is required to make available to the public information from surveys of providers relating to the presence or absence of deficiencies in areas such as staffing, fire safety, and sanitation. Following completion of a survey of a health care facility or organization, those portions of the survey findings relating to statutory requirements as well as major additional health and safety requirements will be matters of public record. In the case of Medicare, such information will be available for inspection within 90 days of completion of the survey upon request in social security district offices and, in the case of Medicaid, the information will be available in local welfare offices. The provision is effective April 1973. (Section 299D)

Waiver of recovery of incorrect payments from survivor who is without fault under Medicare.--Where a survivor is liable for payment of a Medicare overpayment to a deceased beneficiary, recovery of the overpaid amount may be waived if the survivor is without fault in incurring the overpayment. This provision applies beginning with overpayments outstanding as of October 30, 1972. (Section 261)

Waiver of recovery of erroneous payment.--Medicare's right of recovery of an erroneous payment is limited to a 3-year period from the date of the payment, where the institution or person involved acted in good faith. Similarly, the Secretary would specify a reasonable period of time (not to exceed 3 years) after which Medicare would not be required to accept claims for underpayment or nonpayment. The limit on right of recovery applies to notices of payment sent after 1968. The limit on filing claims applies to services furnished after 1970. (Section 281)

Payment to laboratories under the supplementary medical insurance program for diagnostic tests.--The Secretary is authorized, with respect to diagnostic laboratory tests for which payment is to be made to a laboratory on the basis of an assignment by the beneficiary, to negotiate a payment rate with the laboratory which would be considered the full charge for such tests. Reimbursement would be made at 100 percent of such negotiated rate, which would be limited to an amount not exceeding the payment that would have been made in the absence of such rate. (Section 279)

Modification of role of the Health Insurance Benefits Advisory Council.--The role of the Health Insurance Benefits Advisory Council is limited to that of advising the Secretary on matters of general policy in the administration of Medicare and Medicaid. (Section 288)

Financing.--Consistent with past policy of maintaining the social security program on a sound financial basis, provision is made for meeting the cost of the expanded program. The costs of the cash benefits program and the hospital insurance program are to be financed by revised contribution rate schedules. For 1973, the combined contribution rate for cash benefits and hospital insurance is increased from the previously scheduled 5.5 percent each for employers and employees to 5.85 percent each. The provisions relating to the earnings base for tax and benefit purposes in the law (as amended in July 1972) are retained: the maximums of $10,800 for 1973 and of $12,000 for 1974, with automatic increases thereafter as wages rise. The cost estimates underlying the contribution rates were based on the new financing principles adopted earlier in 1972 under Public Law 92-336.

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As a result of the 1972 Amendments, a serious actuarial imbalance in the financing of the hospital program of -0.63% of payroll was eliminated and the program placed on a sound financial basis. P.L. 92-336 increased the contribution rates in future years and the earnings bases to which they would apply by enough to raise the actuarial balance to +0.01% of payroll. P.L. 92-603 fully financed all improvements in program benefits, so that the actuarial balance of the program remains +0.01% of payroll. Also under both of these acts explicit provision is made for increasing the wage base to which the contribution rates apply according to the increase in average earnings in employment covered by Social Security. The financing of the hospital insurance program had always been set under the assumption that such adjustments would be made. The tax rates under previous law, under P.L. 92-336, and under P.L. 92-603 are shown in the following table.

Contribution Rates

Calendar Year	Employer, employee and self-employed rate, each		
	Previous Law	Public Law 92-336	Public Law 92-603
1972	0.60%	0.60%	0.60%
1973-75	.65	.90	1.00
1976-77	.70	.90	1.00
1978-79	.70	1.00	1.25
1980	.80	1.00	1.25
1981-85	.80	1.00	1.35
1986	.80	1.10	1.45
1987-92	.90	1.10	1.45
1993-97	.90	1.20	1.45
Earnings Bases			
1972	$9,000	9,000	9,000
1973	9,000	10,800	10,800
1974	9,000	12,000	12,000

A discussion of the financial status of the program is available in the Annual Report of the Board of Trustees of the Hospital Insurance program. Discussion of the specific effect of P.L. 92-336 and P.L. 92-603 on the financial status of the program can be found in "Actuarial Cost Estimates for the Old-age, Survivors, Disability, and Hospital Insurance System as modified by the Social Security Provision of Public Law 92-336," published by the Office of the Actuary, Social Security Administration, September 1972, and in a similar publication, "Actuarial Cost Estimates for the Old-age, Survivors, Disability, Hospital, and Supplementary Medical Insurance Systems as modified by Public Law 92-603," prepared for use of the House Committee on Ways and Means by the Office of the Actuary, Social Security Administration, March 2, 1973.

APPENDIX D

ADMINISTRATIVE STRUCTURE OF THE MEDICARE PROGRAM

Overall responsibility for administration of Medicare is vested by law in the Secretary of Health, Education, and Welfare. The statute also provides for significant participation in certain areas of administration by private organizations and public agencies.

Within the Department of Health, Education, and Welfare, primary responsibility for administering the Medicare program is assigned to the Social Security Administration (SSA), under the overall guidance of the Assistant Secretary of Health in matters of health policy. Special responsibilities in connection with the health care standards of Medicare have been assigned to the Public Health Service, and certain responsibilities regarding relations between Medicare and State medical assistance programs are coordinated by SSA and the Social and Rehabilitation Service. Responsibility for assuring compliance by participating health care facilities with Title VI of the Civil Rights Act of 1964 is assigned to the Office of Civil Rights of the Department.

Role of the Social Security Administration

The Social Security Administration negotiates and administers agreements with the intermediaries and carriers which perform payment and other program functions; with the State agencies which certify health facilities for participation in the program; and with hospitals and other institutions which provide services for which the program makes reimbursement; develops reimbursement principles and guidelines; works with the Public Health Service in the formulation and periodic review of the conditions of participation; formulates Medicare regulations; develops program policy and procedural instructions; and performs the basic recordkeeping and data processing functions required for administration of the program. Within SSA, the Bureau of Health Insurance has responsibility for the formulation of policies and procedures and for the overall administration of the health insurance program.

In addition to the Bureau of Health Insurance, many other SSA components have substantial program responsibilities. SSA's field organization -- including approximately 1,300 district and branch offices, and more than 3,000 contact stations throughout the country -- carries out enrollment activities and serves as a readily accessible source of program information and direct service to beneficiaries, the professional community, and the general public. In addition, district offices perform certain claims development and investigative activities for Medicare carriers and intermediaries.

The Office of Research and Statistics collects data on program operations and carries out analytical studies designed to evaluate the program and measure its performance.

The Office of the Actuary has responsibility for the actuarial evaluation of the hospital insurance and medical insurance programs, including the preparation of the actuarial estimates used in setting the medical insurance premium, hospital insurance deductible and coinsurance amounts, and, the hospital insurance premium for uninsured individuals.

The Office of Public Affairs which has primary responsibility for developing and coordinating SSA's information activities, works with the Bureau of Health Insurance in the preparation of exhibits, films, visual aids, booklets and other materials needed to inform the general public, as well as special professional audiences, about program benefits and requirements and claims procedures.

The Bureau of Data Processing, through its electronic data processing capabilities, maintains the millions of records on beneficiary eligibility, utilization of covered services, and deductible status. The Bureau also sends premium notices to, and maintains records on the payment of medical insurance premiums by the approximately 3.25 million enrollees who make direct payments or for whom premium payment is made through State agency "buy-in" arrangements or through private retirement groups.

An insurance compliance staff in the Office of Administration assures that the intermediaries and carriers assisting in the administration of Medicare fully comply with equal employment opportunity requirements.

Role of the Public Health Service

The Public Health Service (both at its headquarters and in its regional offices) acts as a primary resource regarding professional health aspects of the Medicare program, participating with the Social Security Administration in formulating and revising the conditions of participation for providers of services, developing policies on the role of State agencies, providing assistance to the State agencies in carrying out their Medicare responsibilities, supporting and evaluating experimental approaches to utilization review and providing professional advice in many technical and medical areas of program administration.

Role of the Social and Rehabilitation Service

The Social and Rehabilitation Service collaborates with the Social Security Administration and the Public Health Service in those aspects of program planning, coordination, and evaluation involving the interrelationships of the health insurance program with State public assistance and medical assistance programs. In addition, the Social and Rehabilitation Service provides consultation and general and technical assistance to State agencies administering medical assistance programs to assure effective coordination between Medicare and the programs at the State level.

Role of the Office of Civil Rights

Title VI of the Civil Rights Act of 1964 provides that no institution agency or activity receiving Federal financial assistance may engage in discriminatory practice on the basis of race, color or national origin. Thus before any hospital, skilled nursing facility or home health agency may become a provider under Medicare, its compliance with the provisions of title VI must be assured. The Department's Office of Civil Rights determines whether Medicare providers meet this requirement and investigates complaints of discrimination.

Role of the State Agencies[1/]

The law requires that, wherever possible, the Secretary use the services of appropriate State or local health agencies or other appropriate State or local agencies in determining whether providers of services and independent laboratories meet the conditions for participation in the Medicare program. All 54 jurisdictions (including the District of Columbia, Puerto Rico, the Virgin Islands and Guam) have designated agencies--in most instances State health agencies--to perform this function.

In carrying out their Medicare responsibilities, State agencies conduct field surveys of institutions and agencies to determine the extent to which they meet the conditions of participation, undertake periodic resurveys of participating facilities to determine whether they continue to meet such conditions, provide consultative services to facilities experiencing difficulties in meeting the participation requirements, identify nonparticipating hospitals which can be reimbursed under the program for emergency services and coordinate activities under the health insurance program with activities under medical assistance programs. The State agencies are reimbursed for the costs of activities they perform in the program including related costs of administrative overhead and staff.

1/ A list of State agencies having agreements with the Secretary of Health, Education, and Welfare under the Medicare program follows in this Appendix as Exhibit 1.

Role of the Intermediaries[2/]

Participating hospitals, skilled nursing facilities, and home health agencies may receive reimbursement either through a fiscal intermediary, or if they prefer, directly from the Government. Virtually all providers have chosen to use intermediaries. Under agreements with the Secretary, intermediaries are responsible for determining the reasonable costs of services provided beneficiaries and for reimbursing providers on behalf of the program. They may also process the Part B claims of the providers of services which they service. In addition, the agreements authorize intermediaries to provide consultative services to providers, audit provider records, and perform related functions. All agreements also require that intermediaries assist providers in establishing and applying safeguards against unnecessary use of services covered by the program. As of June 30, 1973, the Blue Cross Association (with subcontracts to 73 Blue Cross Plans), 5 commercial health insurers, and 4 independent insurers were operating as fiscal intermediaries on behalf of over 13,000 participating providers and 2,900 independent laboratories. Further, 187 hospitals, 86 skilled nursing facilities, 257 home health agencies and 3 rehabilitation agencies were submitting bills directly to SSA.

Role of the Carriers[3/]

The Secretary is authorized by law to contract, to the extent possible, with nongovernmental organizations to serve as carriers for the medical insurance program. To qualify for consideration as a Medicare carrier such an organization must be engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or similar group arrangements, in return for premiums or other periodic charges. As of June 30, 1973, there were 33 Blue Shield plans, 13 insurance companies, 1 independent health insurer and 1 State agency operating as carriers.

2/ A list of intermediaries and carriers operating under agreements with the Secretary of Health, Education, and Welfare follows in this Appendix as Exhibit 2.

3/ A list of intermediaries and carriers operating under agreements with the Secretary of Health, Education, and Welfare follows in this Appendix as Exhibit 2.

Exhibit 1

STATE AGENCIES ADMINISTERING PROVIDER CERTIFICATION

ALABAMA: State Department of Public Health, Montgomery, Alabama

ALASKA: Alaska Department of Health and Social Services, Juneau, Alaska

ARIZONA: State Department of Health, Phoenix, Arizona

ARKANSAS: State Department of Health, Little Rock, Arkansas

CALIFORNIA: State Department of Public Health, Sacramento, California

COLORADO: Department of Health, Denver, Colorado

CONNECTICUT: State Department of Health, Hartford, Connecticut

DELAWARE: Department of Health and Social Services, Dover, Delaware

DISTRICT OF COLUMBIA: District of Columbia Department of Human Resources, Washington, D.C.

FLORIDA: Department of Health and Rehabilitative Services, Jacksonville, Florida

GEORGIA: Georgia Department of Human Resources, Atlanta, Georgia

GUAM: Department of Public Health and Social Services, Agana, Guam

HAWAII: State Department of Health, Honolulu, Hawaii

IDAHO: Department of Environmental and Community Services, Boise, Idaho

ILLINOIS: Illinois Department of Public Health, Springfield, Illinois

INDIANA: State Board of Health, Indianapolis, Indiana

IOWA: State Department of Health, Des Moines, Iowa

KANSAS: State Department of Health, Topeka, Kansas

KENTUCKY: Commonwealth of Kentucky State Department of Health, Frankfort, Kentucky

LOUISIANA: Louisiana Health and Social Rehabilation Services Administration, Baton Rouge, Louisiana

MAINE: Maine Department of Health and Welfare, Augusta, Maine

MARYLAND: Maryland State Department of Health and Mental Hygiene, Baltimore, Maryland

MASSACHUSETTS: Massachusetts Department of Public Health, Boston, Massachusetts

MICHIGAN: Michigan Department of Public Health, Lansing, Michigan

MINNESOTA: State Department of Health, Minneapolis, Minnesota

MISSISSIPPI: Mississippi State Board of Health, Jackson, Mississippi

MISSOURI: State Division of Health, Jefferson City, Missouri

MONTANA: Department of Health and Environmental Sciences, Helena, Montana

NEBRASKA: State Department of Health, Lincoln, Nebraska

NEVADA: State Department of Human Resources, Carson City, Nevada

NEW HAMPSHIRE: New Hampshire Division of Public Health, Concord, N.H.

NEW JERSEY: State Department of Health, Trenton, New Jersey

NEW MEXICO: New Mexico Health and Social Services, Santa Fe, New Mexico

NEW YORK: New York State Department of Health, Albany, New York

NORTH CAROLINA: Department of Human Resources, Raleigh, North Carolina

NORTH DAKOTA: State Department of Health, Bismark, North Dakota

OHIO: Ohio Department of Health, Columbus, Ohio

OKLAHOMA: State Department of Health, Oklahoma City, Oklahoma

OREGON: Department of Human Resources, Portland, Oregon

PENNSYLVANIA: Department of Health, Harrisburg, Pennsylvania

PUERTO RICO: Puerto Rico Department of Health, San Juan, Puerto Rico

RHODE ISLAND: Rhode Island Department of Health, Providence, Rhode Island

SOUTH CAROLINA: State Board of Health, Columbia, South Carolina

SOUTH DAKOTA: State Department of Health, Pierre, South Dakota

TENNESSEE: Tennessee Department of Public Health, Nashville, Tennessee

TEXAS: State Department of Health, Austin, Texas

UTAH: Department of Social Services, Division of Health, Salt Lake City, Utah

VERMONT: Vermont Department of Health, Burlington, Vermont

VIRGIN ISLANDS: Territorial Department of Health, St. Thomas, V.I.

VIRGINIA: State Department of Health, Richmond, Virginia

WASHINGTON: Department of Social and Health Services, Olympia, Washington

WEST VIRGINIA: State Health Department, Charleston, West Virginia

WISCONSIN: Department of Health and Social Services, Madison, Wisconsin

WYOMING: State Department of Health and Social Services, Cheyenne, Wyoming

INTERMEDIARIES AND CARRIERS WHICH PROCESS MEDICARE CLAIMS*

PART A--HOSPITAL INSURANCE

Alabama
Blue Cross-Blue Shield of Alabama
930 South 20th Street
Birmingham, Alabama 35205
Aetna Life and Casualty[1]
Mutual of Omaha Insurance Co.[3]

Alaska
Blue Cross, Washington-Alaska, Inc.
601 Broadway, P.O. Box 327
Seattle, Washington 98111

Arizona
Blue Cross of Arizona, Inc.
321 West Indian School Rd.
P.O. Box 13466
Phoenix, Arizona 85002
Aetna Life and Casualty[1]

Arkansas
Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72203
Aetna Life and Casualty[1]

California
Blue Cross of Southern California
4777 Sunset Boulevard
Los Angeles, California 90027
Blue Cross of Northern California
1950 Franklin Street
Oakland, California 94612
Aetna Life and Casualty[1]
The Travelers Insurance Co.[2]
Mutual of Omaha Insurance Co.[3]
Kaiser Foundation Health Plan, Inc.[4]

Colorado
Colorado Hospital Service
P.O. Box 6410
700 Broadway
Denver, Colorado 80203
Mutual of Omaha Insurance Co.[3]

Connecticut
Connecticut Blue Cross, Inc.
370 Bassett Rd.
North Haven, Connecticut 06473
Aetna Life and Casualty[1]
The Travelers Insurance Co.[2]

PART B--MEDICAL INSURANCE

Alabama
Blue Cross-Blue Shield of Alabama
930 South 20th Street
Birmingham, Alabama 35205

Alaska
Aetna Life and Casualty
1500 S.W. First Avenue
Portland, Oregon 97201

Arizona
Aetna Life and Casualty
3010 West Fairmount Avenue
Phoenix, Arizona 85017

Arkansas
Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72203

California
Counties of: Los Angeles, Orange, San Diego, Ventura, San Bernardino, Imperial, San Luis Obispo, Riverside, Santa Barbara.
Occidental Life Insurance Co. of California
P.O. Box 54905, Terminal Annex
Los Angeles, California 90054
Rest of State:
California Physicians' Service
2 Northpoint,
P.O. Box 7968-Rincon Annex
San Francisco, California 94133

Colorado
Colorado Medical Service, Inc.
P.O. Box 6410
700 Broadway
Denver, Colorado 80203

Connecticut
Connecticut General Life Insurance Co.
900 Cottage Grove Road
Bloomfield, Connecticut 06002

PART A--HOSPITAL INSURANCE--con.

Delaware
Blue Cross and Blue Shield of Delaware
201 West Fourteenth Street
Wilmington, Delaware 19899
District of Columbia
Group Hospitalization, Inc.
550 12th Street, S.W.
Washington, D.C. 20024
Mutual of Omaha Insurance Co.[3]

Florida
Blue Cross of Florida, Inc.
P.O. Box 2711
Jacksonville, Florida 32203
Aetna Life and Casualty[1]
The Travelers Insurance Co.[2]
Mutual of Omaha Insurance Co.[3]

Georgia
Blue Cross of Georgia/Atlanta, Inc.
1010 West Peachtree Street, N.W.
Atlanta, Georgia 30309
Blue Cross of Georgia/Columbus, Inc.
2357 Warm Springs Road,
P.O. Box 1520
Columbus, Georgia 31902
The Travelers Insurance Co.[2]

Hawaii
Hawaii Medical Service Association
1504 Kapiolani Blvd.
P.O. Box 860
Honolulu, Hawaii 96814
Kaiser Foundation Health Plan, Inc.[4]

Idaho
Blue Cross of Idaho, Inc.
1501 Federal Way
P.O. Box 7408
Boise, Idaho 83707
Mutual of Omaha Insurance Co.[3]

Illinois
Hospital Service Corp.
233 North Michigan Ave.
Chicago, Illinois 60601
Illinois Hospital & Health Service, Inc.
227 North Wyman Street
Rockford, Illinois 61101
Aetna Life and Casualty[1]
Mutual of Omaha Insurance Co.[3]
The Travelers Insurance Co.[2]

PART B--MEDICAL INSURANCE--con.

Delaware
Blue Cross and Blue Shield of Delaware
201 West Fourteenth Street
Wilmington, Delaware 19899
District of Columbia
Medical Service of D.C.
550 12th Street, S.W.
Washington, D.C. 20024

Florida
Blue Shield of Florida, Inc.
P.O. Box 2711
Jacksonville, Florida 32203

Georgia
The Prudential Insurance Company of America
Medicare Part B,
P.O. Box 7340, Station C
Atlanta, Georgia 30309

Hawaii
Aetna Life and Casualty
7th Floor Bishop Trust Bldg.
1000 Bishop Street, P.O. Box 3947
Honolulu, Hawaii 96813

Idaho
The Equitable Life Assurance Society
P.O. Box 8084
Boise, Idaho 83707

Illinois
County of Cook:
Illinois Medical Service
233 North Michigan Avenue
Chicago, Illinois 60601
Rest of State:
Continental Casualty Company
P.O. Box 910
Chicago, Illinois 60690

Exhibit 2

* As of March 1974

PART A--HOSPITAL INSURANCE--con.

Indiana

Mutual Hospital Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Aetna Life and Casualty[1]

The Travelers Insurance Co.[2]

Iowa

Blue Cross of Iowa
Liberty Building
Des Moines, Iowa 50307

Blue Cross of Western Iowa and South Dakota
Third and Pierce Streets
Sioux City, Iowa 51102

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

Kansas

Kansas Hospital Service Assoc., Inc.
1133 Topeka Blvd., P.O. Box 239
Topeka, Kansas 66601

Blue Cross of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

Kentucky

Blue Cross Hospital Plan, Inc.
3101 Bardstown Road
Louisville, Kentucky 40205

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

Nationwide Mutual Ins. Co.[5]

Louisiana

Louisiana Hospital Service, Inc.
P.O. Box 15699
Baton Rouge, Louisiana 70815

Hospital Service Association of New Orleans
2026 St. Charles Avenue
New Orleans, Louisiana 70130

Aetna Life and Casualty[1]

Maine

Associated Hospital Service of Maine
110 Free Street
Portland, Maine 04101

The Travelers Insurance Co.[2]

PART B--MEDICAL INSURANCE--con.

Indiana

Mutual Medical Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Iowa

Blue Shield of Iowa
Liberty Building
Des Moines, Iowa 50307

Kansas

Counties of: Johnson, Wyandotte

Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:

Kansas Blue Shield
P.O. Box 239
1133 Topeka Blvd.
Topeka, Kansas 66601

Kentucky

Metropolitan Life Insurance Co.
1218 Harrodsburg Road
Lexington, Kentucky 40501

Louisiana

Pan-American Life Insurance Co.
P.O. Box 60450
New Orleans, Louisiana 70160

Maine

Union Mutual Life Insurance Co.
2211 Congress Street, Box 4629
Portland, Maine 04112

PART A--HOSPITAL INSURANCE--con.

Maryland

Blue Cross of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Group Hospitalization, Inc.
550 12th Street S.W.
Washington, D.C. 20024

Mutual of Omaha Insurance Co.[3]

Massachusetts

Blue Cross of Massachusetts, Inc.
133 Federal Street
Boston, Massachusetts 02106

Aetna Life and Casualty[1]

The Travelers Insurance Co.[2]

Michigan

Michigan Hospital Service
600 Lafayette East
Detroit, Michigan 48226

Aetna Life and Casualty[1]

The Travelers Insurance Co.[2]

Mutual of Omaha Insurance Co.[3]

Minnesota

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55165

Aetna Life and Casualty[1]

The Travelers Insurance Co.[2]

Mississippi

Blue Cross and Blue Shield of Mississippi, Inc.
P.O. Box 1043
Jackson, Mississippi 39205

Mutual of Omaha Insurance Co.[3]

Missouri

Blue Cross Hospital Service, Inc. of Missouri
8000 West Florissant Blvd.
St. Louis, Missouri 63136

Blue Cross of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

PART B--MEDICAL INSURANCE--con.

Maryland

Counties of: Montgomery, Prince Georges.

Medical Service of D.C.
550 12 Street S.W.
Washington, D.C. 20024

Rest of State:

Blue Cross of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Massachusetts

Blue Shield of Massachusetts, Inc.
80 Mason Street
Boston, Massachusetts 02110

Michigan

Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Minnesota

Counties of: Anoka, Dakota, Hennepin, Fillmore, Goodhue, Houston, Ramsey, Washington, Olmstead, Wabasha, Winona.

The Travelers Insurance Co.
8120 Penn Avenue, South
Bloomington, Minnesota 55431

Rest of State:

Blue Cross and Blue Shield of Minnesota
P.O. Box 8899
Minneapolis, Minnesota 55404

Mississippi

The Travelers Insurance Co.
P.O. Box 22545
Jackson, Mississippi 39205

Missouri

Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, De Kalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livington, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth.

Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:

General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166

PART A--HOSPITAL INSURANCE

Montana

Blue Cross of Montana
3360 10th Avenue, South
P.O. Box 5004
Great Falls, Montana 59403

The Travelers Insurance Co.[2]

Mutual of Omaha Insurance Co.[3]

Nebraska

Blue Cross of Nebraska
P.O. Box 3248, Main
Post Office Station
Omaha, Nebraska 68103

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

Nevada

Aetna Life and Casualty
P.O. Box 3077
Reno, Nevada 89505

New Hampshire

New Hampshire-Vermont Hospitalization Service
Two Pillsbury Street
Concord, New Hampshire 03301

The Travelers Insurance Co.[2]

New Jersey

Hospital Service Plan of New Jersey
33 Washington Street
Newark, New Jersey 07102

The Prudential Insurance Company of America
P.O. Box 300
Linwood, New Jersey 08221

New Mexico

New Mexico Blue Cross & Blue Shield
12800 Indian School Road, N.E.
Albuquerque, New Mexico 87112

The Travelers Insurance Co.[2]

PART B--MEDICAL INSURANCE

Montana

Montana Physicians' Service
P.O. Box 2510
Helena, Montana 59601

Nebraska

Mutual of Omaha Insurance Co.
P.O. Box 456, Downtown Station
Omaha, Nebraska 68101

Nevada

Aetna Life and Casualty
P.O. Box 3077
Reno, Nevada 89505

New Hampshire

New Hampshire-Vermont Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

New Jersey

The Prudential Insurance Company of America
P.O. Box 300
Linwood, New Jersey 08221

New Mexico

The Equitable Life Assurance Society
P.O. Box 3070, Station D.
Albuquerque, New Mexico 87110

PART A--HOSPITAL INSURANCE--con.

New York

Blue Cross of Northeastern New York
P.O. Box 8650
Albany, New York 12208

Blue Cross of Western New York
Blue Cross Bldg., 298 Main St.
Buffalo, New York 14202

Chautauqua Region Hospital Service Corp.
306 Spring Street
Jamestown, New York 14701

Blue Cross & Blue Shield of Greater New York
622 Third Avenue
New York, New York 10017

Rochester Hospital Service Corp.
41 Chestnut Street
Rochester, New York 14604

Blue Cross of Central New York
P.O. Box 271
344 South Warren St.
Syracuse, New York 13202

Hospital Plan, Inc.
5 Hopper Street
Utica, New York 13501

Hospital Service Corp. of Jefferson County
158 Stone Street
Watertown, New York 13601

The Travelers Insurance Co.[2]

North Carolina

Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, North Carolina 27702

Aetna Life and Casualty[1]

North Dakota

Blue Cross of North Dakota
301 Eighth Street, South
Fargo, North Dakota 58102

Aetna Life and Casualty[1]

PART B--MEDICAL INSURANCE--con.

New York

Counties of Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Blue Cross & Blue Shield of Greater New York
Two Park Avenue
New York, New York 10016
County of: Queens

Group Health Incorporated
227 West 40th Street
New York, New York 10018
Counties of: Livingston, Monroe, Ontario, Seneca, Wayne, Yates.

Genesee Valley Medical Care, Inc.
41 Chestnut Street
Rochester, New York 14604
Counties of Allegany, Cattaraugus, Erie, Genesee, Niagara, Orleans, Wyoming.

Blue Shield of Western New York
298 Main Street
Buffalo, New York 14202
Counties of: Albany, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Cortland, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St. Lawrence, Tioga, Tompkins, Warren, Washington.

Metropolitan Life Insurance Company
276 Genesee St., P.O. Box 393
Utica, New York 13503

North Carolina

The Prudential Insurance Company of America
Medicare B., P.O. Box 1482
High Point, North Carolina 27261

North Dakota

Blue Shield of North Dakota
301 Eighth Street, South
Fargo, North Dakota 58102

PART A--HOSPITAL INSURANCE--con

Ohio

Blue Cross Hospital Plan, Inc.
201 Ninth Street, N.W.
Canton, Ohio 44702

Blue Cross of Southwest Ohio
1351 Taft Road
Cincinnati, Ohio 45206

Blue Cross of Northeast Ohio
2066 East Ninth Street
Cleveland, Ohio 44115

Blue Cross of Central Ohio
174 East Long Street
Columbus, Ohio 43215

Blue Cross of Lima, Ohio
7 Public Square, P.O. Box 1046,
Lima, Ohio 45802

Blue Cross of Northwest Ohio
P.O. Box 943
Toledo, Ohio 43601

Blue Cross of Eastern Ohio, Inc.
2400 Market Street
Youngstown, Ohio 44507

Aetna Life and Casualty[1]

Kaiser Foundation Health Plan[4]

Nationwide Mutual Insurance Co.[5]

Oklahoma

Blue Cross Association
1215 South Boulder Avenue
Tulsa, Oklahoma 74102

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

Oregon

Blue Cross of Oregon
100 S.W. Market Street
P.O. Box 1271
Portland, Oregon 97207

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

Kaiser Foundation Health Plan[4]

PART B--MEDICAL INSURANCE--con.

Ohio

Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

Oklahoma

Aetna Life and Casualty
1140 N.W. 63rd Street
Oklahoma City, Oklahoma 73116

Department of Institutions, Social and Rehabilitative Services
P.O. Box 25352, State Capital Station
Oklahoma City, Oklahoma 73125

Oregon

Aetna Life and Casualty
1500 S.W. First Avenue
Portland, Oregon 97201

PART A--HOSPITAL INSURANCE--con.

Pennsylvania

Blue Cross of Lehigh Valley
1221 Hamilton Street
Allentown, Pennsylvania 18102

Capital Blue Cross
100 Pine Street
Harrisburg, Pennsylvania 17101

Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Blue Cross of Western Pennsylvania
1 Smithfield Street
Pittsburgh, Pennsylvania 15222

Blue Cross of Northeastern Pennsylvania
Blue Cross Building
[illegible] South Franklin Street
Wilkes-Barre, Pennsylvania 18701

Inter-County Hospitalization Plan, Inc.
Foxcroft Square
Jenkintown, Pennsylvania 19046

The Travelers Insurance Co.[2]

Rhode Island

Blue Cross of Rhode Island, Inc.
444 Westminster Mall
Providence, Rhode Island 02901

The Travelers Insurance Co.[2]

South Carolina

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29206

South Dakota

Blue Cross of Western Iowa and South Dakota
Third and Pierce Streets
Sioux City, Iowa 51102

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

Tennessee

Blue Cross-Blue Shield of Tennessee
Blue Cross Building
Chattanooga, Tennessee 37402

Memphis Hospital Service & Surgical Association, Inc.
P.O. Box 98
Memphis, Tennessee 38101

Aetna Life and Casualty[1]

Texas

Group Hospital Service, Inc.
Main at North Central Expressway
Dallas, Texas 75222

Aetna Life and Casualty[1]

Mutual of Omaha Insurance Co.[3]

PART B--MEDICAL INSURANCE--con.

Pennsylvania

Pennsylvania Blue Shield
Blue Shield Building
Camp Hill, Pennsylvania 17011

Rhode Island

Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

South Carolina

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29206

South Dakota

South Dakota Medical Service, Inc.
711 North Lake Avenue
Sioux Falls, South Dakota 57104

Tennessee

The Equitable Life Assurance Society
P.O. Box 1465
Nashville, Tennessee 37202

Texas

Group Medical and Surgical Service
Blue Cross Bldg.
Main at North Central Expressway
Dallas, Texas 75222

PART A--HOSPITAL INSURANCE--con.

Utah
Blue Cross of Utah
2455 Parley's Way, Box 270
Salt Lake City, Utah 84110
Mutual of Omaha Insurance Co.[3]

Vermont
New-Hampshire-Vermont Hospitalization Service
Two Pillsbury Street
Concord, New Hampshire 03301
The Travelers Insurance Co.[2]

Virginia
Blue Cross of Virginia
2015 Staples Mill Road
P.O. Box 27401
Richmond, Virginia 23261
Blue Cross of Southwestern Virginia
1212 Third Street, S.W.
P.O. Box 2770
Roanoke, Virginia 24001
Group Hospitalization, Inc.
550 12th Street, S.W.
Washington, D.C. 20024
Aetna Life and Casualty[1]
[illegible]

Washington
Blue Cross, Washington-Alaska, Inc.
601 Broadway, P.O. Box 327
Seattle, Washington 98111
Aetna Life and Casualty[1]
Mutual of Omaha Insurance Co.[3]

West Virginia
Blue Cross Hospital Service, Inc.
Box 1353, Commerce Square
Charleston, West Virginia 25301
Parkersburg Hospital Service, Inc.
203 Union Trust Bldg.
Parkersburg, West Virginia 26101
West Virginia Hospital Service, Inc.
21st and Chopline Streets
Wheeling, West Virginia 26003
Mutual of Omaha Insurance Co.[3]

PART B--MEDICAL INSURANCE--con.

Utah
Blue Shield of Utah
2455 Parley's Way, Box 270
Salt Lake City, Utah 84110

Vermont
New-Hampshire-Vermont Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

Virginia
Counties of: Arlington, Fairfax.
City of: Alexandria.
Medical Service of D.C.
550 12th Street, S.W.
Washington, D.C. 20024
Rest of State:
The Travelers Insurance Co.
P.O. Box 26463
Richmond, Virginia 23261

Washington
Washington Physicians Service
220 West Harrison Street
Seattle, Washington 98119

West Virginia
Nationwide Mutual Insurance Co.[5]
P.O. Box 3183
Charleston, West Virginia 25332

PART A--HOSPITAL INSURANCE--con.

Wisconsin
Associated Hospital Service, Inc.
4115 North Teutonia Avenue
Milwaukee, Wisconsin 53201
Aetna Life and Casualty[1]
The Travelers Insurance Co.[2]
Mutual of Omaha Insurance Co.[3]

Wyoming
Wyoming Hospital Service
4020 House Avenue
P.O. Box 2266
Cheyenne, Wyoming 82001

Puerto Rico
Blue Cross of Florida, Inc.
P.O. Box 2711
Jacksonville, Florida 32203
Cooperativa de Seguros de Vida de Puerto Rico
P.O. Box 3428 G.P.O.
San Juan, Puerto Rico 00936

Virgin Islands
Cooperativa de Seguros de Vida de Puerto Rico
P.O. Box 3428 G.P.O.
San Juan, Puerto Rico 00936

American Samoa
Hawaii Medical Service Association
P.O. Box 860
Honolulu, Hawaii 96814

Guam
Hawaii Medical Service Association
P.O. Box 860
Honolulu, Hawaii 96814
Kaiser Foundation[4]

PART B--MEDICAL INSURANCE--con.

Wisconsin
County of Milwaukee:
The Medical Society of Milwaukee County
756 North Milwaukee Street
Milwaukee, Wisconsin 53202
Rest of State:
Wisconsin Physicians Service
1717 Broadway
Madison, Wisconsin 53701

Wyoming
The Equitable Life Assurance Society
P.O. Box 628, 3151 Nationway
Cheyenne, Wyoming 82001

Puerto Rico
Seguros de Servicio de Salud de Puerto Rico
G.P.O. 3628
San Juan, Puerto Rico 00936

Virgin Islands
Seguros de Servicio de Salud de Puerto Rico
G.P.O. 3628,
San Juan, Puerto Rico 00936

American Samoa
Hawaii Medical Service Association
P.O. Box 860
Honolulu, Hawaii 96814

Guam
Aetna Life and Casualty
P.O. Box 3947
Honolulu, Hawaii 96813

NOTE: The Blue Cross Association, 840 North Lake Shore Drive, Chicago, Ill. 60611 is the contractor for all Blue Cross plans participating in the hospital insurance program. The Aetna Life and Casualty processes claims from providers of services from 27 States; The Travelers Insurance Co. from 18 States; Mutual of Omaha Insurance Co. from 24 States and the District of Columbia; the Kaiser Foundation Health Plan, Inc., from 5 States; and Nationwide Mutual Insurance Co. from 2 States. The main office for each of these companies is listed below:

[1] Aetna Life and Casualty, 151 Farmington Avenue, Hartford, Conn. 06115
[2] The Travelers Insurance Co., One Tower Square, Hartford, Conn. 06115
[3] Mutual of Omaha Insurance Co., Box 456, Downtown Station, Omaha, Nebr. 68101
[4] Kaiser Foundation Health Plan, Inc., 1956 Webster St., Room 310-A, Oakland, California 94612
[5] Nationwide Mutual Insurance Co., P.O. Box 57, Columbus, Ohio 43216